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ABSTRACT

This KIDS COUNT databook is the eighth annual profile examining statewide trends in the well-being of Rhode Island's children. The statistical portrait is based on 53 indicators (3 new indicators in this databook) in 5 areas: (1) family and community (including child population, children in single parent families, and racial and ethnic diversity); (2) economic well-being (including child support, child poverty, children in families receiving food stamps, children in the Family Independence Program, and children receiving school breakfast); (3) health (including children's health insurance, children with special needs, breastfeeding incidence, dental care access, children's mental health, infant mortality, and births to teens); (4) safety (including child and teen deaths, homeless children and youth, children of incarcerated parents, juveniles referred to family court, and out-of-home placement); and (5) education (including infant/preschool child care, Head Start enrollment, school-age child care, child care subsidies, special education enrollment, student mobility, fourth-grade reading skills, high performing schools, school attendance, and high school graduation). Following an overview focusing on family economic security and

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educational attainment, the databook defines each indicator, describes its significance and trends, describes efforts to address problems or meet needs, and for most indicators presents relevant data for the state, 39 cities and towns, and an aggregate of the 5 cities with the highest child poverty rates. The databook concludes by describing the methodology, listing KIDS COUNT committee members, and acknowledging contributors. (KB)

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2003 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation and The Annie E. Casey Foundation. Additional funding is provided by Prince Charitable Trusts, The Ewing Marion Kauffman Foundation, The Robert Wood Johnson Foundation, the David and Lucile Packard Foundation, the Ford Foundation, CVS/pharmacy, Hasbro Charitable Trust, and other corporate, foundation and individual sponsors.

The annual *Rhode Island KIDS COUNT Factbook* is one of fifty state-level projects designed to provide a detailed community-by-community picture of the condition of children. A national Factbook with comparable data for the U.S. is produced annually by The Annie E. Casey Foundation.

Additional copies of the *2003 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *2003 Factbook*, please contact:

Rhode Island KIDS COUNT
One Union Station
Providence, RI 02903
Phone: 401-351-9400
Fax: 401-351-1758
E-Mail: rikids@rikidscount.org

Visit our Web site at www.rikidscount.org.

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2003 Rhode Island KIDS COUNT Factbook

PARTNERS

The Rhode Island Foundation

Ronald V. Gallo, President
Karen Voci, Senior Vice President for Program
Rick Schwartz, Vice President of Communications

Brown University
A. Alfred Taubman Center for Public Policy and American Institutions

Darrell M. West, Director
Thomas J. Anton, Professor
Jack D. Combs, Research Administrator

Rhode Island College
School of Social Work

Nancy Gewirtz, Director, Poverty Institute
George Metrey, Dean, School of Social Work

Rhode Island KIDS COUNT

Elizabeth Burke Bryant, Executive Director
Catherine Boisvert Walsh, Deputy Director
Wilsa Galarza, Administrative Assistant
Olinda Matos, Communications Coordinator
Dorene Bloomer, Finance Director
Laura Beavers, Research Analyst
Veronika Kot, Policy Analyst
Amy Lapierre, Covering Kids and Families Project Director
Sonia Rodrigues-Carr, Pawtucket Covering Kids and Families Coordinator
Theresa Hancock, Policy Associate
Royce Conner, Policy Associate
Raymonde Charles, Program Assistant
Jason Anthony, Publications Assistant
Joanna Ruocco, Intern, Brown University
Sarah Jones, Intern, University of Rhode Island

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She will Gather Roses

This little girl
only born to
gather wild roses.
Only born to
shake the wild rice loose
with her little fingers
Only to collect the sap
of young hemlocks
in spring. This woman
child was only born
to pick strawberries.
fill baskets with
blueberries, soapberries,
elderberries. This
little girl was
only born to
gather wild roses.

Anonymous Native American

The *2003 Rhode Island KIDS COUNT Factbook* is the ninth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *2003 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide policy, programs for children, and individual service on behalf of children.

The *2003 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the six cities in which more than 15% of the children live in poverty. These cities — referred to as the core cities in the Factbook — are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter - the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

The *2003 Rhode Island KIDS COUNT Factbook* examines fifty-two indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. Three new indicators are included in this edition of the Factbook. The most current and reliable data available are presented for each indicator.

Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate has increased from 14% in 1990 to 17% in 2000. Nearly half of Rhode Island's 40,177 poor children live in extreme poverty - with a family income less than $9,122 (half of the federal poverty level of $18,244 for a family of four). Even those with incomes above the official poverty level have a difficult time meeting the high costs of housing, utilities, child care, and health care. Child care subsidies, health insurance, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.

Educational Attainment

Improving student achievement and high school graduation rates in Rhode Island requires that all sectors work together to provide opportunities for infants, young children, and teens in the state's high poverty neighborhoods. Children who participate in high-quality preschool programs and read on grade level by fourth grade are more likely to complete high school. Student achievement can be improved when schools have high expectations for all students, effective curricula and teaching methods, adequate accountability methods, and prepared and sufficiently supported teachers. Young people who complete high school prepared to go on to higher education or to enter the workforce are more likely to be capable, self-sufficient adults who contribute to the community.

Results for All Children

Significant racial and ethnic disparities in child outcomes continue to exist in Rhode Island. Black, Hispanic, Asian and Native American children are three times more likely than White, non-Hispanic children to be poor and more likely to live in Rhode Island's poorest urban neighborhoods. Strategic efforts that engage diverse leadership can ensure that all Rhode Island children have the resources they need to thrive, including economic security, effective schools, quality child care, quality health care, affordable housing, and caring communities.

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Child Population

DEFINITION

Child population is the total number of children under the age of 18 and the percentage change between 1990 and 2000 in the total number of children under age 18.

SIGNIFICANCE

In 2000, the number of family households with children under age 18 in Rhode Island was 124,867, comprising almost a third (31%) of all Rhode Island households.[1] According to the decennial census of April 2000, there were 1,048,319 Rhode Island residents. Of these, 24% or 247,822 were children under age 18. This is a 10% increase since 1990. There were 22,132 more children in Rhode Island in 2000 than in 1990.[2]

The number of U.S. children recorded by Census 2000 was the largest in history at 72.3 million.[3] This represents a substantial increase in the child population over the decade of the 1990s. Children now make up 26% of the U.S. population.[4]

In general, children in Rhode Island at the start of the 21st century are older and more ethnically diverse than those children living in the state in the previous decade. The largest increase in any age category between 1990 and 2000 was in the number of children in early adolescence (ages 10 to 14). The number of Rhode Island children between the ages of 10 and 14 increased by 20% in the decade, increasing from 59,406 to 71,370.[5] In contrast the number of children under age 5 living in Rhode Island dropped by nearly 5%, decreasing from 66,969 in 1990 to 63,896 in 2000.[6]

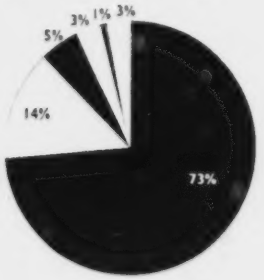
The percentage change in the total population under age 18 varied widely among towns in Rhode Island. The largest increase was in West Greenwich where the child population increased by 58%.[7] Although the child population increased in most Rhode Island towns, some locations had decreases. Both Burrillville and Newport had reductions of 10% in the number of residents under age 18.[8]

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. Nationally, and in Rhode Island, the increase in the child population was led by minority children.[9] In Rhode Island, the number of White, non-Hispanic children declined over the decade of the 1990s by nearly 9,000 children, while the number of minority children increased by 31,000 to nearly 68,000.[10]

Rhode Island's Children, 2000

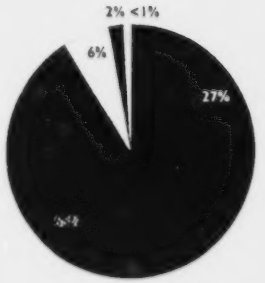
By Race/Ethnicity*

73%	White
14%	Hispanic
5%	African American
3%	Asian and Pacific Islander
1%	Some Other Race
3%	Two or More Races



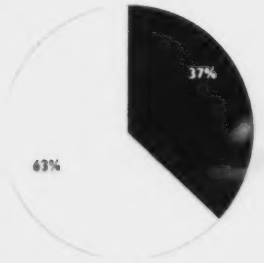
By Family Structure

27%	Single Parent Families**
65%	Married Couple Families**
6%	Other Relatives
2%	Unrelated Individuals
<1%	Group Quarters



By Residence

37%	Core Cities***
63%	Remainder of State



n = 247,822

**Hispanics are not included in any other racial group. Two or more races was not possible as a selection in the 1990 census.*

***Includes only children who are related to the head of household by birth or adoption.*

****According to Census 2000, there are now six core cities in Rhode Island, i.e., communities in which 15% or more of the children live in families with income below the federal poverty level. There are 91,945 children who live in one of the six core cities: Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.*

Source: U.S. Census Bureau, Census 2000.

She will Gather Roses

This little girl
only born to
gather wild roses.
Only born to
shake the wild rice loose
with her little fingers
Only to collect the sap
of young hemlocks
in spring. This woman-
child was only born
to pick strawberries,
fill baskets with
blueberries, soapberries,
elderberries. This
little girl was
only born to
gather wild roses.

Anonymous Native American

Mother to Son

Well, son, I'll tell you:
Life for me ain't been no crystal stair.
It's had tacks in it,
And splinters,
And boards torn up,
And places with no carpet on the floor—
Bare.
But all the time
I'se been a-climbin' on,
And reachin' landin's,
And turnin' corners,
And sometimes goin' in the dark
Where there ain't been no light.
So boy, don't you turn back.
Don't set down on the steps
'Cause you finds it's kinder hard.
Don't you fall now—
For I'se still goin', honey,
I'se still climbin',
And life for me ain't been no crystal stair.

Langston Hughes

Table 1.

Child Population, Rhode Island, 1990 and 2000

CITY/TOWN	1990 TOTAL POPULATION UNDER AGE 18	2000 TOTAL POPULATION UNDER AGE 18	CHANGE IN POPULATION UNDER AGE 18	% CHANGE IN POPULATION UNDER AGE 18
Barrington	3,912	4,745	833	21%
Bristol	4,380	4,399	19	0%
Burrillville	4,479	4,043	-436	-10%
Central Falls	4,810	5,531	721	15%
Charlestown	1,575	1,712	137	9%
Coventry	7,626	8,389	763	10%
Cranston	14,673	17,098	2,425	17%
Cumberland	6,427	7,690	1,263	20%
East Greenwich	2,913	3,564	651	22%
East Providence	10,657	10,546	-111	-1%
Exeter	1,521	1,589	68	5%
Foster	1,185	1,105	-80	-7%
Glocester	2,526	2,664	138	6%
Hopkinton	1,839	2,011	172	9%
Jamestown	1,123	1,238	115	10%
Johnston	5,332	5,906	574	11%
Lincoln	3,890	5,157	1,267	33%
Little Compton	750	780	30	4%
Middletown	4,676	4,328	-348	-7%
Narragansett	2,869	2,833	-36	-1%
New Shoreham	163	185	22	14%
Newport	5,756	5,199	-557	-10%
North Kingstown	6,076	6,848	772	13%
North Providence	5,655	5,936	281	5%
North Smithfield	2,332	2,379	47	2%
Pawtucket	16,719	18,151	1,432	9%
Portsmouth	4,175	4,329	154	4%
Providence	37,972	45,277	7,305	19%
Richmond	1,565	2,014	449	29%
Scituate	2,426	2,635	209	9%
Smithfield	3,898	4,019	121	3%
South Kingstown	4,770	6,284	1,514	32%
Tiverton	3,166	3,367	201	6%
Warren	2,452	2,454	2	0%
Warwick	18,322	18,780	458	3%
West Greenwich	915	1,444	529	58%
West Warwick	6,560	6,632	72	1%
Westerly	4,988	5,406	418	8%
Woonsocket	10,617	11,155	538	5%
Core Cities	*82,434*	*91,945*	*9,511*	*12%*
Remainder of State	*143,256*	*155,877*	*12,621*	*9%*
Rhode Island	*225,690*	*247,822*	*22,132*	*10%*

Source of Data for Table/Methodology

U.S. Census Bureau, 1990 Census of the Population and Census 2000, Summary File 1.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1,11,13] U.S. Bureau of the Census, Census 2000 Summary File 1.

[12] O'Hare, W. (June 2001) *The Child Population: First Data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation and The Population Reference Bureau.

[14] *America's Children: Key National Indicators of Well-Being* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[14] U.S. Bureau of the Census, 1990 Census of Population and Census 2000.

Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person — male or female — without a spouse present in the home. These numbers include own children defined as never-married children under age 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

Children living in single-parent families are at increased risk of living in poverty compared to children living in two-parent families. In 2001, 35% of single-parent families with children under age 18 were living below the poverty level compared to only 4% of married-couple families.[1] In 2001, the average household income in Rhode Island for two-parent families with children was $81,271 compared to $56,296 for single-parent families headed by a man and $34,158 for single-parent families headed by a woman.[2] Of the 67,978 Rhode Island children who lived in single-parent families in 2000, 83% lived in households headed by a female.[3]

Most of the 247,822 children in Rhode Island live in family households (92%). The remainder live with other relatives (6%), other unrelated individuals (2%), or in group quarters, including juvenile detention facilities, hospitals and group homes (less than 1%).[4]

Following the national trend, more Rhode Island children are growing up in single-parent households than any time since the census began collecting information on household living arrangements. In 1970, only 12% of children in Rhode Island lived in single-parent families, compared to 23% in 1990 and 30% in 2000.[5]

Of all Rhode Island children living with at least one biological or adoptive parent, 70% lived in married-couple families and the remaining 30% (67,978) lived in single-parent families.[6] White children and Asian children are far more likely to live in married-couple families than are Black, Hispanic and Native American children.[7] The core cities, those with child poverty rates higher than 15%, continue to have the highest rates of children living in single-parent families.[8]

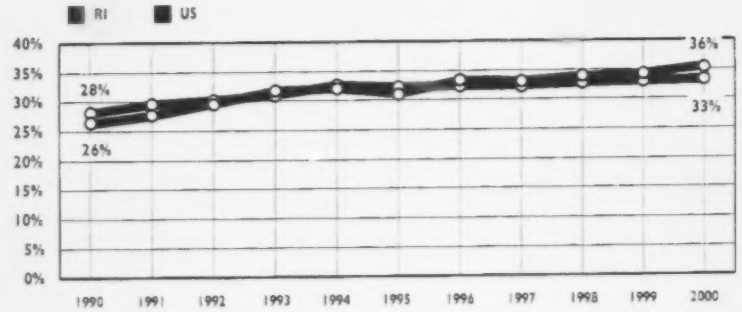
Single Parent Families

	1990	2000
RI	23%	32%
US	24%	30%
State Rank		*34th*

1st is best; 50th is worst

Source: *Children At Risk: State Trends 1999-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Births to Unmarried Women as a Percentage of All Births, Rhode Island and the United States, 1990 – 2002



Source: *The Right Start for America's Newborns: A Decade of City and State Trends 1990 – 2000* (2003). Baltimore, MD: The Annie E. Casey Foundation. Percentage is based on total number of births.

◆ In Rhode Island, the percentage of births to unmarried mothers has increased from 26% in 1990 to 36% in 2000. Rhode Island is ranked 11th in the country for the highest rates of births to unmarried mothers.[9]

◆ In Providence in 2000, 58% of all births were to unmarried women. When compared with the 50 largest cities in the country, Providence ranks 6th for the highest rates of births to unmarried women.[10]

◆ Children born to unmarried mothers are more likely to grow up in single-parent families and to experience multiple living arrangements during childhood. These multiple living arrangements are associated with reduced educational attainment, increased likelihood of sexual activity during adolescence, and teen pregnancy and parenting.[11]

◆ Children in single-parent families, children born to unmarried mothers and children in cohabitating relationships are at higher risk for poor outcomes than are children living in households headed by two parents in a low-conflict marriage.[12,13]

Table 2.

Children's Living Arrangements, Rhode Island, 2000

CITY/TOWN	ALL CHILDREN LIVING IN FAMILY HOUSEHOLDS	NUMBER OF CHILDREN UNDER 18 YEARS			
		TWO-PARENT FAMILIES		SINGLE PARENT FAMILIES	
		N	%	N	%
Barrington	4,592	4,091	89%	501	11%
Bristol	4,092	3,222	79%	870	21%
Burrillville	3,737	3,077	82%	660	18%
Central Falls	4,977	2,607	52%	2,370	48%
Charlestown	1,586	1,305	82%	281	18%
Coventry	7,807	6,287	81%	1,520	19%
Cranston	15,626	11,817	76%	3,809	24%
Cumberland	7,273	6,049	83%	1,224	17%
East Greenwich	3,476	3,042	88%	434	12%
East Providence	9,682	6,919	71%	2,763	29%
Exeter	1,461	1,248	85%	213	15%
Foster	1,037	914	88%	123	12%
Glocester	2,453	2,082	85%	371	15%
Hopkinton	1,893	1,576	83%	317	17%
Jamestown	1,194	1,018	85%	176	15%
Johnston	5,440	4,303	79%	1,137	21%
Lincoln	4,895	3,930	80%	965	20%
Little Compton	740	627	85%	113	15%
Middletown	4,150	3,363	81%	787	19%
Narragansett	2,641	2,002	76%	639	24%
New Shoreham	171	139	81%	32	19%
Newport	4,835	2,723	56%	2,112	44%
North Kingstown	6,546	5,255	80%	1,291	20%
North Providence	5,411	3,973	73%	1,438	27%
North Smithfield	2,221	1,922	87%	299	13%
Pawtucket	16,525	9,537	58%	6,988	42%
Portsmouth	4,136	3,476	84%	660	16%
Providence	40,267	19,721	49%	20,546	51%
Richmond	1,867	1,590	85%	277	15%
Scituate	2,490	2,179	88%	311	12%
Smithfield	3,800	3,184	84%	616	16%
South Kingstown	5,887	4,789	81%	1,098	19%
Tiverton	3,121	2,598	83%	523	17%
Warren	2,288	1,657	72%	631	28%
Warwick	17,276	13,571	79%	3,705	21%
West Greenwich	1,368	1,198	88%	170	12%
West Warwick	6,084	4,101	67%	1,983	33%
Westerly	5,077	3,759	74%	1,318	26%
Woonsocket	10,269	5,562	54%	4,707	46%
Core Cities	*82,957*	*44,251*	*53%*	*38,706*	*47%*
Remainder of State	*145,434*	*116,162*	*80%*	*29,272*	*20%*
Rhode Island	*228,391*	*160,413*	*70%*	*67,978*	*30%*

Note to Table

The denominator is the number of children under age 18 living in family households according to the census. A family household is defined by the U.S. Census Bureau as consisting of a householder and one or more people living together in the same household who are related to the householder by birth, marriage or adoption - it may also include others not related to the householder.

Source of Data for Table/Methodology

U.S. Bureau of the Census. 1990 Census of Population and Census 2000. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[4] U.S. Bureau of the Census, Current Population Survey, 2000 to 2002 average.

[5][6][7] U.S. Bureau of the Census, Census 2000, Summary File One.

[8] Census Data Online. (January 2001). http://www.aecf.org/kidscount/census. Baltimore, MD: The Annie E. Casey Foundation. KIDS COUNT.

[9][10] *The Right Start for America's Newborns: A Decade of City and State Trends* (1990 – 2000). (2003). Baltimore, MD: The Annie E. Casey Foundation.

[11] Terry-Humen, E., et. al. (April 2001). *Birth Outside of Marriage: Perceptions vs. Reality.* Washington, DC: Child Trends.

[12] Anderson Moore, K., et. al. (June 2002). *Marriage from a Child's Perspective: How Does Family Structure Affect Children, and What Can We Do about It?* Washington, DC: Child Trends.

[13] Acs, G. and S. Nelson (July 2002). *The Kids Are Alright? Children's Well-Being and the Rise in Cohabitation.* Washington, DC: The Urban Institute.

Mother's Education Level

DEFINITION

Mother's education level is the percentage of total births to women with less than a high school diploma. Data are self-reported at the time of the infant's birth. Although a father's education level has a major impact on his child's development, this indicator uses mother's education level because a significant number of birth records lack information on father's education level.

SIGNIFICANCE

The level of parental educational attainment can affect many aspects of child well-being. Research shows that there are strong links between parental education levels and a child's school readiness, health in adolescence and the level of education that the child will ultimately achieve.[1] Higher education levels of parents have been shown to contribute to a more supportive home learning environment for children.[2]

Children of parents with higher education levels are much less likely to grow up in economically-disadvantaged households. In the US in 2001, people without a high school diploma earned only two-thirds of the earnings of a high school graduate, and only a little more than one-third of the earnings of an individual with a bachelor's degree.[3] Children of immigrants and children of color are least likely to have parents with high educational levels.[4,5] Higher educational attainment increases earnings across all racial and ethnic categories.[6]

Rhode Island has education levels nearly equal to U.S. averages but lags behind other New England states on almost all levels of educational attainment.[7] There are currently 153,086 Rhode Island adults age 25 years and older with less than a high school diploma.[8] Of these adults, 37% have less than a 9th grade education.[9]

Of the 9,309 Rhode Island children born to mothers with less than a high school diploma between 1997 and 2001, 105 were to teen mothers under the age of 15 and 1,796 were to mothers from 15 to 17 years old.[10] Teen mothers are far less likely to complete high school than teenage women who did not give birth.[11]

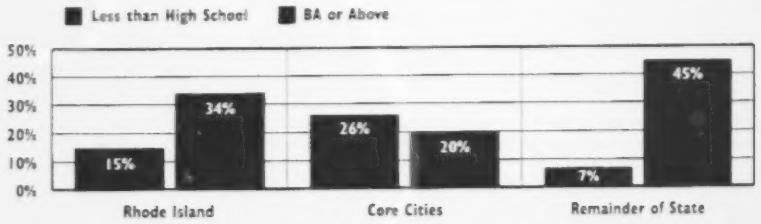
Percent of Total Births to Mothers with Less than 12 Years of Education

	1990	2000
RI	19%	15%
US	24%	22%
State Rank		*18th*

1st is best; 50th is worst

Source: *KIDS COUNT DATA BOOK State Profile in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Births by Maternal Educational Attainment, Rhode Island, Core Cities, Remainder of State, 1997-2001



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001 average.

◆ In Rhode Island between 1997 and 2001, there were 9,309 infants born to mothers with less than a high school diploma. This was 15% of all births in Rhode Island, 26% of all births in the core cities, and 7% of all births in the remainder of the state.[12]

◆ In Rhode Island, Native American children (34%), Hispanic children (34%), Black children (22%) and Asian children (18%) are more likely to be born to a mother with less than a high school diploma than are White children (14%).[13]

Literacy and English Proficiency in Rhode Island

◆ Adults with the lowest literacy levels are more likely to live in poverty and be unemployed or underemployed. Children of adults who participate in literacy programs improve their grades and test scores, improve their reading skills, and are less likely to drop out of school.[14]

◆ Many of Rhode Island's children have parents who do not speak English well. According to Census 2000, there were 20,799 households that were linguistically-isolated, i.e., households in which no member 14 years old and over speaks English "very well". In addition, there were 36,412 adults who did not speak English or do not speak English "well".[15]

Births by Education Level of Mother, Rhode Island, 1997-2001

Table 3.

CITY/TOWN	ALL BIRTHS	BACHELOR'S DEGREE OR ABOVE		SOME COLLEGE		HIGH SCHOOL DIPLOMA		LESS THAN HIGH SCHOOL DIPLOMA	
		N	%	N	%	N	%	N	%
Barrington	820	617	75%	107	13%	75	9%	6	1%
Bristol	1,067	466	44%	219	21%	293	28%	77	7%
Burrillville	781	247	32%	183	23%	259	33%	62	8%
Central Falls	1,781	132	7%	220	12%	645	36%	704	40%
Charlestown	446	175	39%	112	25%	114	26%	39	9%
Coventry	1,924	794	41%	391	20%	595	31%	131	7%
Cranston	4,171	1,755	42%	848	20%	1,159	28%	340	8%
Cumberland	1,701	851	50%	346	20%	373	22%	101	6%
East Greenwich	588	412	70%	83	14%	75	13%	12	2%
East Providence	2,499	828	33%	480	19%	875	35%	268	11%
Exeter	341	170	50%	52	15%	97	28%	19	6%
Foster	197	85	43%	41	21%	58	29%	10	5%
Glocester	464	190	41%	124	27%	117	25%	27	6%
Hopkinton	488	185	38%	97	20%	175	36%	24	5%
Jamestown	205	163	80%	18	9%	15	7%	4	2%
Johnston	1,492	592	40%	317	21%	454	30%	106	7%
Lincoln	990	472	48%	193	20%	234	24%	58	6%
Little Compton	157	98	62%	22	14%	28	18%	6	4%
Middletown	1,083	457	42%	258	24%	309	29%	54	5%
Narragansett	667	393	59%	115	17%	121	18%	29	4%
New Shoreham	57	29	51%	15	26%	9	16%	2	4%
Newport	1,645	559	34%	317	19%	457	28%	296	18%
North Kingstown	1,500	916	61%	227	15%	266	18%	71	5%
North Providence	1,576	596	38%	345	22%	474	30%	128	8%
North Smithfield	515	258	50%	95	18%	124	24%	25	5%
Pawtucket	5,030	970	19%	867	17%	1,906	38%	1,121	22%
Portsmouth	917	520	57%	182	20%	179	20%	26	3%
Providence	13,589	2,759	20%	1,723	13%	4,677	34%	3,725	27%
Richmond	473	215	46%	95	20%	131	28%	28	6%
Scituate	506	255	50%	104	21%	117	23%	23	5%
Smithfield	805	447	56%	160	20%	159	20%	21	3%
South Kingstown	1,298	781	60%	193	15%	213	16%	90	7%
Tiverton	649	246	38%	163	25%	186	29%	53	8%
Warren	582	224	39%	129	22%	161	28%	58	10%
Warwick	4,428	1,761	40%	936	21%	1,348	30%	329	7%
West Greenwich	297	158	53%	49	17%	77	26%	10	3%
West Warwick	2,024	495	25%	381	19%	788	39%	335	17%
Westerly	1,375	406	30%	303	22%	496	36%	155	11%
Woonsocket	2,980	360	12%	472	16%	1,200	40%	736	25%
Core Cities	*27,049*	*5,275*	*20%*	*3,980*	*15%*	*9,673*	*36%*	*6,917*	*26%*
Remainder of State	*35,059*	*15,762*	*45%*	*7,002*	*20%*	*9,366*	*27%*	*2,392*	*7%*
Rhode Island	*62,108*	*21,037*	*34%*	*10,982*	*18%*	*19,039*	*31%*	*9,309*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional. Data are self-reported and reported by the mother's place of residence, not the place of the infant's birth. Data may not include all births among Rhode Island residents that occurred out of state.

Note that for 1,741 births between 1997 – 2001, the education level of the mother was unknown and for two births the place of residence was unknown.

References for Indicator

[i] *Parental Education, Child Trends Databank*, February 2003, www.childtrends.org

[ii] *Knowledge and Skills for Life, Parental Education, OECD Programme for International Student Assessment*, February 2003, www.pisa.oecd.org

[iii] *Money Income in the United States: 2001* (September 2002). Washington, DC: U.S. Bureau of the Census.

[iv] *America's Children: Key National Indicators of Well-Being, 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[v] [vi] U.S. Bureau of the Census, Census 2000.

[vii] [viii] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001.

[ix] *Teen Mothers: Selected Socio-Demographic Characteristics and Risk Factors* (June 1998). Washington, DC: United States General Accounting Office.

[x] *Fact Sheet: Adult and Family Literacy* (April 2000). Washington, DC: National Institute for Literacy

Racial and Ethnic Diversity

DEFINITION

Racial and ethnic diversity is the number of children under age 18 by racial and ethnic categories as defined by the U.S. Census Bureau for the 2000 U.S. Census of the Population. For children living in households, racial and ethnic categories are chosen by the head of household or person completing the census form.

SIGNIFICANCE

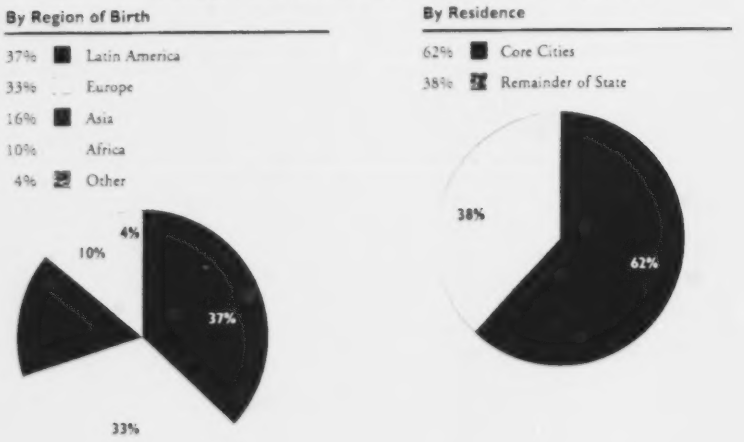
Racial and ethnic diversity has increased significantly in the United States over the last several decades. With increased immigration and higher fertility rates among minorities, diversity is projected to continue to rise in the future.[1] Nationally, minority children (all those except White, non-Hispanic children) accounted for 98% of the growth in the child population during the 1990s.[2] In 1980, nearly three quarters (74%) of all U.S. children under age 18 were White, non-Hispanic. This number has dropped to less than two-thirds (64%) in 2000. By 2020, slightly more than half (55%) of all children in the United States are projected to be White, non-Hispanic.[3]

In Rhode Island, 73% of children in the state were White, non-Hispanic in 2000, compared to 84% in 1990.[4,5] The number of children of color nearly doubled from 36,867 in 1990 to nearly 67,747 in 2000. The number of White, non-Hispanic children dropped by 8,748 during the same time period.[6,7] Minority children are highly concentrated in the core cities. More than half (58%) of the 91,945 children living in the core cities are minority children. More than three-quarters (78%) of all minority children in Rhode Island live in these six communities.[8]

Immigrant children are also more likely to live in one of the core cities. There are 31,415 households in Rhode Island headed by immigrant parents of children under age 18.[9] Compared to children born in the U.S., children in immigrant families are more likely to live in two-parent working households but more likely to be poor and have health problems. In addition, their families are less able to draw from community resources including extracurricular activities, food, health, mental health and housing assistance in times of need.[10]

Diversity presents opportunities and challenges to schools, child care centers, health care providers, social service agencies and other community service providers. Programs will need to adapt their current practices to meet the needs of a changing population.[11]

Foreign-Born Individuals, Rhode Island, 2000



n = 119,277

Source: U.S. Census Bureau, Census 2000.

Immigration in Rhode Island

◆ Over the last ten years, there has been an increase in the number of foreign-born individuals living in Rhode Island. The immigrant population in Rhode Island grew by 31% between 1990 and 2000, increasing from 91,061 individuals in 1990 to 119,277 in 2000.[12,13] Just under half (47%) of these Rhode Islanders are naturalized citizens.[14]

◆ Nearly two out of every three (62%) foreign-born individuals in Rhode Island live in the core cities. Most of the foreign-born individuals from Africa (81%) and from Latin America (88%) live in the core cities.[15]

◆ In 2001, Rhode Island was home to 8,476 individuals under age 18 who were born outside the United States, 3% of all the children in the state.[16] These numbers are likely to be an underestimate as immigrant children are among the most likely to be undercounted by population estimates.[17]

Table 4

Child Population, by Race and Ethnicity, Rhode Island, 2000

	UNDER AGE 18 BY RACE AND ETHNICITY								
CITY/TOWN	HISPANIC OR LATINO	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN AND ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN AND OTHER PACIFIC	SOME OTHER RACE	TWO OR MORE RACES	2000 POPULATION UNDER AGE 18
Barrington	59	4,479	29	8	106	0	4	60	4,745
Bristol	88	4,183	30	3	21	4	3	67	4,399
Burrillville	59	3,915	11	8	6	0	11	33	4,043
Central Falls	3,122	1,574	292	29	22	0	225	267	5,531
Charlestown	38	1,597	7	26	12	0	1	31	1,712
Coventry	151	7,975	47	8	46	2	10	150	8,389
Cranston	1,213	14,041	513	59	796	5	71	400	17,098
Cumberland	231	7,185	65	5	70	3	38	93	7,690
East Greenwich	59	3,308	30	1	106	0	11	49	3,564
East Providence	360	8,366	681	48	114	4	323	650	10,546
Exeter	36	1,484	9	9	8	0	0	43	1,589
Foster	17	1,054	2	1	11	2	3	15	1,105
Glocester	31	2,573	15	2	10	0	1	32	2,664
Hopkinton	35	1,889	11	27	10	0	3	36	2,011
Jamestown	19	1,183	14	4	4	0	0	14	1,238
Johnston	203	5,425	63	9	93	1	21	91	5,906
Lincoln	151	4,694	73	2	116	1	21	99	5,157
Little Compton	12	756	1	0	2	0	0	9	780
Middletown	201	3,549	246	23	104	1	15	189	4,328
Narragansett	69	2,566	27	52	25	0	5	89	2,833
New Shoreham	3	175	3	0	3	0	0	1	185
Newport	602	3,485	555	86	55	7	51	358	5,199
North Kingstown	210	6,286	70	37	76	0	11	158	6,848
North Providence	377	5,033	208	12	122	3	48	133	5,936
North Smithfield	17	2,305	13	8	15	0	1	20	2,379
Pawtucket	3,820	10,090	1,776	53	131	7	1,251	1,023	18,151
Portsmouth	114	4,016	55	5	58	0	8	73	4,329
Providence	20,350	10,858	7,606	621	3,043	19	575	2,205	45,277
Richmond	32	1,916	7	19	8	0	0	32	2,014
Scituate	30	2,535	10	1	24	1	5	29	2,635
Smithfield	50	3,880	18	2	29	0	2	38	4,019
South Kingstown	128	5,561	87	126	169	0	19	194	6,284
Tiverton	46	3,234	15	4	18	0	8	42	3,367
Warren	36	2,294	38	4	11	1	6	64	2,454
Warwick	516	17,220	217	50	322	1	35	419	18,780
West Greenwich	13	1,396	4	3	7	0	5	16	1,444
West Warwick	384	5,792	86	29	102	3	26	210	6,632
Westerly	96	4,931	45	45	143	0	11	135	5,406
Woonsocket	2,024	7,272	606	29	591	5	46	582	11,155
Core Cities	*30,302*	*39,071*	*10,921*	*847*	*3,944*	*41*	*2,174*	*4,645*	*91,945*
Remainder of State	*4,700*	*141,004*	*2,664*	*611*	*2,665*	*29*	*700*	*3,504*	*155,877*
Rhode Island	*35,002*	*180,075*	*13,585*	*1,458*	*6,609*	*70*	*2,874*	*8,149*	*247,822*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000 Redistricting File.

All categories are mutually exclusive. If Hispanic was selected as ethnicity, individuals are not included in other racial categories. Likewise, if more than one race was selected, individuals are included in two or more races and not in their individual race categories.

The core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] Pollard, K. and O'Hare, W. (1999). *America's Racial and Ethnic Minorities.* Washington, DC: Population Reference Bureau.

[2] O'Hare, W. (June 2001). *The Child Population: First Data from the 2000 Census.* Baltimore ,MD: The Annie E. Casey Foundation and The Population Reference Bureau.

[3] *America's Children: Key National Indicators of Well-Being* (2002) Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4] U.S. Bureau of the Census, Census 2000.

[5] U.S. Bureau of the Census, 1990 Census of the Population.

[6] U.S. Bureau of the Census, Current Population Survey, 2000 to 2002.

[7] Edmonston, B. (May 2002). *A KIDS COUNT/PRB Special Report: The Undercount in the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation.

[8] Reardon-Anderson, J., et al (November 2002). *The Health and Well-Being of Children in Immigrant Families.* Washington, DC: The Urban Institute.

[9] *Speaking for America's Children: Child Advocates Identify Children's Issues and the 2002 State Priorities* (January 2002). Washington, DC: National Association of Child Advocates.

Racial and Ethnic Disparities

DEFINITION

Racial and ethnic disparities is the gap that exists in outcomes for children of different racial and ethnic groups in Rhode Island. Child well-being outcome areas include economic well-being, health, education and safety.

SIGNIFICANCE

Rhode Island's children are diverse in race, ethnic background, language and country of origin. During the 1990s, the percentage of minority children in Rhode Island increased from 16% to 27%, with a particularly large increase in the number of Hispanic children.[1] Although there have been substantial improvements in child well-being over the last century across racial and ethnic lines, large disparities still exist between White, non-Hispanic children and children from other racial and ethnic groups.

The growing diversity of Rhode Island's children is not evenly distributed. Increasingly, minority children are concentrated in core urban communities which also have increasingly high rates of child poverty.[2] More than three quarters (77%) of Rhode Island's minority children live in one of the six core cities where child poverty rates are over 15%.[3] Three-quarters of the children in Providence (76%) and in Central Falls (72%) are of minority racial and ethnic backgrounds.[4] In several neighborhoods of Providence, children of color now comprise over 90% of all children. These neighborhoods have some of the highest child poverty rates in the state.[5]

Research demonstrates a significant relationship between residence in low-income or poor neighborhoods and increased teen pregnancy and high-school drop out rates.[6] When compared with White, non-Hispanic children in poverty, Black and Hispanic children living in families with income below the poverty line are more likely to live in neighborhoods in which 40% or more of the residents live in poor families.[7]

The racial and ethnic segregation of U.S. neighborhoods over the past three decades, while decreasing overall, decreased less for children than the general population, and was countered by increased school segregation.[8] The Providence-Warwick-Fall River, MA metropolitan area was the second most segregated large metropolitan area in the nation for Hispanics in 2000, and was also the metropolitan area with the largest increase in segregation between 1980 and 2000.[9] More than three-quarters of Rhode Island's Latinos live in Providence, Pawtucket or Central Falls.[10]

Rhode Island's Native American Children

◆ According to Census 2000, there were 1,877 children who were identified as Native American or Alaska Native living in Rhode Island.[11] Three-quarters of the Native American children in Rhode Island live in the towns of Providence, South Kingstown, Newport, Cranston, Pawtucket, Narragansett, Warwick and East Providence.[12] There were 3,901 children identified in the Census as Native American or Alaska Native in combination with another race.[13]

Economics

◆ Native American children are among the most likely to live in families with incomes below the poverty threshold.[14] More than 50% of the 1,877 Native American children in Rhode Island are poor, compared to 17% of children overall.[15]

◆ Household income in these families is low at $22,813 compared to $42,090 statewide.[16] Native American children are the most likely to live in a single parent family, with 62% of children living in single parent families compared to 30% of all children in Rhode Island.[17] Only 34% of Native Americans in Rhode Island live in housing that they own compared to 60% overall and 71% of White, non-Hispanic households.[18]

Health

◆ Rhode Island children of Native American background are the most likely of all racial backgrounds in the state to be born without adequate prenatal care (17% compared to 9% overall) and to women with less than a high school diploma (34% compared to 15% overall).[19] Rhode Island Native American teens are nearly four times as likely to be teen mothers as other teens in the state (83.0 per 1,000 teens compared to 22.5 per 1,000 overall).[20]

Education

◆ Native Americans in Rhode Island have lower educational attainment levels than the population overall. Only 78% of Native American youth graduate from high school compared to 84% of all youth in the state.[21] Of those Native Americans 25 years of age and over, 14% hold a bachelor's degree or higher compared to 26% of all Rhode Islanders.[22]

Economic Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children in poverty	8%	47%	38%	26%	51%	17%
% with maternal education < 12 years	14%	34%	22%	18%	34%	15%
% children with all parents in the workforce	65%	49%	63%	54%	50%	62%
Median household income	$45,314	$22,851	$24,973	$36,473	$22,813	$42,090
Homeownership	71%	24%	33%	48%	34%	60%

Source: U.S. Census Bureau, Census 2000 all except Maternal Education Levels from Rhode Island Department of Health, Maternal and Child Health Database. All Census 2000 data refers to only those individuals who selected one race. Black, Asian and Native American categories include both those individuals who identified themselves as Hispanic and those who identified themselves as non-Hispanic.

◆ In 2000, there were 40,177 poor children in Rhode Island. Sixty-four percent of Rhode Island's poor children are children of color. Rhode Island's child poverty rates for Hispanic and Asian children are significantly higher than the U.S. rates for these racial and ethnic groups.[23]

◆ Children living in single parent families are much more likely to be poor. Native American, Black, and Hispanic children in Rhode Island are about twice as likely to live in a single-parent family as their White counterparts. In 2000 in Rhode Island, 24% of White children, 62% of Native American children, 61% of Black children, and 53% of Hispanic children lived in single parent families.[24]

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Women with delayed prenatal care	8.1%	13.5%	15.3%	15.1%	16.5%	9%
Births to teens ages 15 – 17 (per 1,000 teens)	21.7	62.6	51.1	43.7	83.0	22.5
Infants born low birthweight	6.7%	7.4%	11.8%	9.1%	10.7%	7.4%
Children under age 6 with high lead levels (>= 10ug/dL)	5%	10%	18%	12%	NA	7%

Source: Rhode Island Department of Health, Office of Family Health, 1997-2001 (prenatal care, teen births, low birthweight).Teen births were calculated for Native American teens based on births for the five year period and denominator from the 2000 Census. Information based on self-reported race and ethnicity. Rhode Island Department of Health, Childhood Lead Poisoning Prevention Program based on highest lead test result during calendar year 2002. Data for Native American children not reported because only 27 children were tested.

◆ Although much progress has been made on many health indicators, racial and ethnic disparities still exist for a number of child outcomes. Minority women are far more likely to have delayed obtaining prenatal care and are much more likely to have given birth while still teenagers.[25]

◆ In 1999 in Rhode Island, 9% of White adults were uninsured as compared with 17% of Blacks, 14% of Asians/Pacific Islanders and 10% of Hispanics.[26] Comparable data for Rhode Island children are not available. Nationally, Hispanic children and poor children are the most likely to be uninsured.[27]

Racial and Ethnic Disparities

Safety Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Juveniles at the Training School (per 1,000)	2.7	7.1	16.9	NA	NA	4.3
Children of Incarcerated Parents (per 1,000)	9.9	23.7	92.9	NA	NA	15.7
Children in Out of Home Placement (per 1,000)	3.6	5.6	19.6	2.5	11.4	4.6

Source: *Juveniles at the Training School:* Rhode Island KIDS COUNT analysis of Rhode Island Department of Children Youth and Families, based on children who passed through the RITS between 1/1/02-12/31/02. *Children of Incarcerated Parents:* Rhode Island KIDS COUNT analysis of data from the Rhode Island Department of Justice, 2002. *Children in Out-of-Home Placement:* Rhode Island KIDS COUNT analysis of data from the Department of Children Youth and Families RICHIST Database from December 2000, January 2002 and January 2003. All denominators based on children under age 18 by race from Census 2000. Information not reported for Native American and Asian children because one year of data does not produce statistically reliable rates.

◆ Racial and ethnic minority groups continue to be disproportionately represented in the child welfare and juvenile justice systems. Research shows that minority youth are more likely than White, non-Hispanic youth to be placed in secure detention, even when the type and severity of the offense is the same.[28] In the U.S., Black youth adjudicated for drug offenses with no prior admissions were incarcerated 48 times as often as their White counterparts. Similarly, Latino youth adjudicated for violent offenses remained in state institutions for 150 days longer than White youth adjudicated for the same offenses.[29]

◆ National data indicate that poor families and families of color are more likely to have their child removed and placed in foster care. Once in foster care, children of color are more likely to remain there for longer periods of time and to experience multiple placements in different homes.[30]

Education Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
% of Children Attending Low Performing Schools	26%	82%	74%	63%	46%	39%
4th Grade Children Meeting the Standard for Reading						
Basic Understanding	83%	50%	52%	62%	58%	74%
Analysis and Interpretation	71%	32%	34%	42%	45%	60%
High School Graduation Rate	87%	72%	76%	83%	78%	84%
% of Adults Over Age 25 with a Bachelor's Degree or Higher	27%	9%	17%	36%	14%	26%

Source: *Attending Low Performing Schools:* Rhode Island KIDS COUNT analysis of Rhode Island Department of Elementary and Secondary Education, 2002 School Performance Categories, denominator is school enrollment by race 2001-2002 school year. *4th Grade Reading Scores:* Rhode Island State Assessment Program, Report of Student Performance by Demographic Characteristics, State Report Grade 4, Spring 2002 Data. *High School Graduation Rate:* Rhode Island Department of Elementary and Secondary Education. *Adult Educational Attainment:* Census 2000.

◆ Currently in Rhode Island, children of color are far more likely to attend low-performing schools than are White children. Rhode Island's Hispanic and Black children are more than three times as likely as White children to attend a low-performing school.[31]

◆ Children of color are more likely to be identified as needing special education. According to the *2000-2001 Biennial Performance Report of Children with Disabilities in Rhode Island*, a disproportionate number of Black, Hispanic, and Asian students were represented in special education placement.[32]

Immigrant Children

◆ In 2001, Rhode Island was home to 8,476 children under age 18 who were born outside the United States, 4% of all children in the state.[33] This is likely to be an underestimate as immigrant children are among the most likely undercounted by population estimates. Between 1990 and 2000 in Rhode Island, the tota. nmigrant population grew by 25%, increasing from 95,088 to 119,277.[34]

◆ An additional 31,415 Rhode Island households with children under age 18 are headed by immigrants.[35] Children of immigrants are the fastest growing segment of the United States population under age 18.[36] Nationally, over half (52%) of all children of immigrants lived in families with incomes below 200% of the Federal Poverty threshold.[37]

◆ Children of immigrants living in two-parent working families are substantially more likely to be low-income than their native-born counterparts. Lower wages, not employment levels, account for most of this income disparity.[38] Children of immigrants are more likely than children of native-born parents to be in fair or poor health and lack health insurance; live in families with problems affording food but receive no food stamps; and live in crowded housing but receive no housing assistance.[39]

◆ In Rhode Island, 21% of immigrants (including those born in Puerto Rico) are poor compared with 11% of native born people.[40] Two out of three (65%) immigrants live in the core cities, of these two-thirds live in Providence and Central Falls.[41] Immigrants tend to live in poorer neighborhoods within these cities and to live in more crowded housing units.[42] Half (48%) of immigrants in Rhode Island are not naturalized citizens.[43]

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References for Indicator

[1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43] U.S. Bureau of the Census, Census 2000.

[3] Census 2000 data as analyzed by The Providence Plan: www.provplan.org, February 2003.

[4] *Trends in the Well-Being of America's Children and Youth* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[5] *The Report of the Century Foundation Task Force on the Common School Divided We Fail: Coming Together through Public School Choice* (2002). New York, NY: The Century Foundation.

[7] Iceland, J et al (August 2002). *Racial and Ethnic Residential Segregation in the United States 1980 - 2000.* Washington, DC: U.S. Census Bureau.

[8] Goodluck, C. and Willeto A. (December 2001). *Native American Kids 2001: Indian Children's Well-Being Indicators Data Book.* Seattle WA: Casey Family Programs and Flagstaff, AZ: Northern Arizona University.

[9,10,11,12] *2000 Census Data: Race Profile for Rhode Island, Population Reference Bureau. Analysis of data from the U.S. Census Bureau,* 2000 Census Summary File 1 (Tables P28A - P28G) www.kidscount.org, February 2003, Annie E. Casey Foundation.

[13,20,21] Rhode Island Department of Health, Division of Family Health Maternal and Child Health Database, based on births between 1997 - 2001.

[31] Rhode Island Department of Elementary and Secondary Education, 2001 - 2002 School Year.

[45] Nolan, P. (March 2002). *Disparities in Health Coverage among Adults in Rhode Island.* Providence, RI: Rhode Island Department of Health.

[47] *Health Insurance Coverage: 2001* Table H108 (September 2002). Washington DC: U.S. Census Bureau.

[48] *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (September 1998). Washington, DC: Council of Economic Advisors for the Presidents Initiative on Race.

[49,50] Soler, M. (October 2001). *Public Opinion on Youth Crime and Race: A Guide for Advocates.* San Francisco, CA: Youth Law Center.

[51] Rhode Island KIDS COUNT analysis of data from the Rhode Island Department of Elementary and Secondary Education.

[52] *Biennial Performance Report of Children with Disabilities in Rhode Island* (May 2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[53,54] U.S. Bureau of the Census, Current Population Survey, 2000 - 2002.

[36,37,38,39] Reardon-Anderson, J et al (November 2002). *The Health and Well-Being of Children in Immigrant Families.* Washington, DC: The Urban Institute.

[41,42] Capps, R. and Passel, J. (January 2003). *The New Neighbors: A User's Guide to Data on Immigrants in U.S. Communities.* Washington, DC: The Urban Institute.

And My Heart Soars

The beauty of the trees, the softness of the air,
the fragrance of the grass, speaks to me.
The summit of the mountain, the thunder of the sky,
the rhythm of the sea, speaks to me.
The faintness of the stars, the freshness of the morning,
the dew drop on the flower, speaks to me.
The strength of fire, the taste of salmon, the trail of the sun,
And the life that never goes away, They speak to me.
And my heart soars.

Chief Dan George

Median Household Income

DEFINITION

Median household income is the median annual income for all Rhode Island households. The median income is the dollar amount which divides the income distribution into two equal groups – half with income above the median and half with income below the median.

SIGNIFICANCE

Median income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. According to Census 2000, one-half of all Rhode Island families with children under age 18 earned less than $50,557 and one-half earned more. The 1999 median income for all households – including those without children – was $42,090.[1]

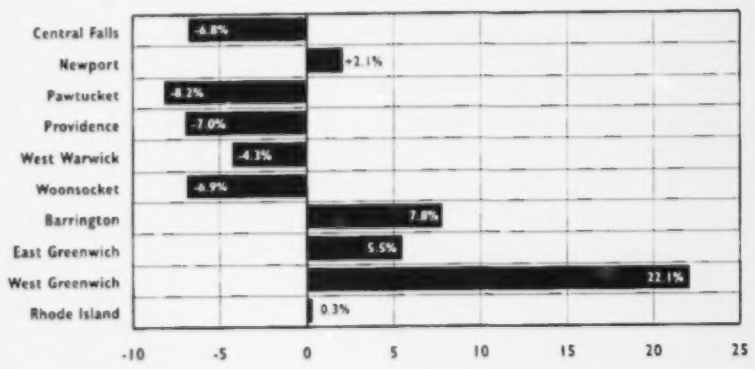
After reaching an all time high in 2000, the U.S. median household income decreased in 2001 by 2.2%. Income inequality continued to increase.[2] In 2001, the share of national income held by the wealthiest 5% was the highest on record while the average incomes for all other income categories continued to drop.[3] Rhode Island was among the ten states where income inequality between the top and bottom of the income distribution grew most in the 1980s and 1990s.[4]

Communities with above-average income inequality have higher mortality rates than communities with comparable incomes but lower inequality.[5] Families are at increased risk for homelessness when their incomes fall even while the economy grows, as they are less likely to be able to afford higher housing costs.[6] Increased income disparities lead to geographic segregation as wealthier families move to the suburbs. This can result in unequal school funding from property taxes.[7]

Due to the tight labor market and the increase in the minimum wage, very low-paid workers experienced slight wage increases in the late 1990s.[8] In 2001, the wage for a low-wage worker in Rhode Island (those in the bottom fifth of the wage scale) was $8.61, 7% above the national rate.[9]

Earnings increase dramatically with education level. Higher educational attainment results in increased earnings across all racial and ethnic categories.[10] In Rhode Island, women with a high school diploma earn 43% more than those without one. Women still earn less than men across all educational levels.[11]

Change in Median Household Income, 1989 – 1999, Core Cities, Three Highest Income Communities, and Rhode Island



Source: U. S. Bureau of the Census, Census 2000. Percentage change is based on median household income for 1989 and 1999 adjusted to 1999 dollars.

◆ After adjusting for inflation, Rhode Island's highest income communities experienced significant increases in median household income between 1989 and 1999 while the lowest income communities had real declines in income.[12]

◆ Of the six core cities, those communities with child poverty rates over 15%, only Newport experienced an increase in real income over the decade of the 1990s.[13]

◆ Income is highly correlated with educational attainment. In Rhode Island's lowest-income communities, adults over age 25 are far less likely to have completed high school and less likely to have completed some college, obtained a bachelor's degree or completed a graduate degree.[14]

◆ In the U.S. in 2001, people without a high school diploma earned only two-thirds (64%) of the earnings of a high school graduate and less than half (45%) of the earnings of an individual with a bachelor's degree.[15]

Table 5.

Adjusted Median Household Income, Rhode Island - 1989* and 1999

CITY/TOWN	ADJUSTED 1989 MEDIAN HOUSEHOLD INCOME*	1999 MEDIAN HOUSEHOLD INCOME	1999 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18
Barrington	$69,222	$74,591	$88,794
Bristol	$44,573	$43,689	$53,328
Burrilville	$48,476	$52,587	$55,085
Central Falls	$24,289	$22,628	$22,008
Charleston	$47,020	$51,491	$55,080
Coventry	$48,572	$51,987	$61,355
Cranston	$45,047	$44,108	$56,904
Cumberland	$53,077	$54,656	$68,291
East Greenwich	$66,401	$70,062	$108,555
East Providence	$40,453	$39,108	$48,875
Exeter	$49,810	$64,452	$73,239
Foster	$53,223	$59,673	$63,385
Glocester	$52,186	$57,537	$60,938
Hopkinton	$47,929	$52,181	$59,069
Jamestown	$54,166	$63,073	$79,574
Johnston	$42,526	$43,514	$56,641
Lincoln	$48,379	$47,815	$64,470
Little Compton	$53,735	$55,368	$56,679
Middletown	$45,960	$51,075	$55,301
Narragansett	$46,374	$50,363	$68,250
New Shoreham	$41,059	$44,779	$54,844
Newport	$39,836	$40,669	$43,125
North Kingstown	$52,733	$60,027	$66,785
North Providence	$42,168	$39,721	$50,493
North Smithfield	$54,076	$58,602	$71,066
Pawtucket	$34,627	$31,775	$33,562
Portsmouth	$55,414	$58,835	$67,375
Providence	$28,894	$26,867	$24,546
Richmond	$53,458	$59,840	$63,472
Scituate	$58,931	$60,788	$69,135
Smithfield	$55,478	$55,621	$67,050
South Kingstown	$47,595	$56,325	$68,265
Tiverton	$47,189	$49,977	$63,820
Warren	$41,275	$41,285	$53,542
Warwick	$46,688	$46,483	$57,038
West Greenwich	$53,817	$65,725	$70,150
West Warwick	$41,260	$39,505	$41,830
Westerly	$45,459	$44,613	$51,974
Woonsocket	$33,090	$30,819	$34,465
Core Cities	*NA*	*NA*	*NA*
Remainder of State	*NA*	*NA*	*NA*
Rhode Island	*$41,985*	*$42,090*	*$50,557*

**Adjusted to 1999 dollars*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000

Median household income data includes households with both related and unrelated individuals. Median family income data includes only households with children under age 18 who meet the Census Bureau's definition of a family. The Census Bureau defines a family as a household that includes a householder and one or more people living in the same household who are related to the household by birth, marriage or adoption. The 1989 adjusted median household income data is adjusted to 1999 constant dollars by multiplying 1989 dollar values by 1.304650 as recommended by the U.S. Census Bureau.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] [2] [3] U.S. Bureau of the Census, Census 2000.

[4] *Census Data Show Increases in the Extent and Severity of Poverty and Decline in Household Income* (September 2002). Washington, DC: Center on Budget and Policy Priorities.

[5] [6] [7] Bernstein, J., McNichol, E.C., Mishel, L. et al. (April 2002). *Pulling Apart: A State-By State analysis of Income Trends*. Washington, DC: Center on Budget and Policy Priorities and the Economic Policy Institute.

[8] Mishel, L. and Bernstein, J. (2002). *The State of Working America 2002-2003*. Washington, DC: Economic Policy Institute.

[9] [10] *Money Income in the United States: 2001* (September 2002). Washington, DC: U.S. Bureau of the Census.

[11] *The Status of Women in Rhode Island* (November 2002). Washington, DC: The Institute for Women's Policy Research.

Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a very low-income family to cover the average cost of rent, including heat. A very low-income family is defined as a family with income less than 50% of the median. Rent burdens over 30% of monthly income are considered unaffordable.

SIGNIFICANCE

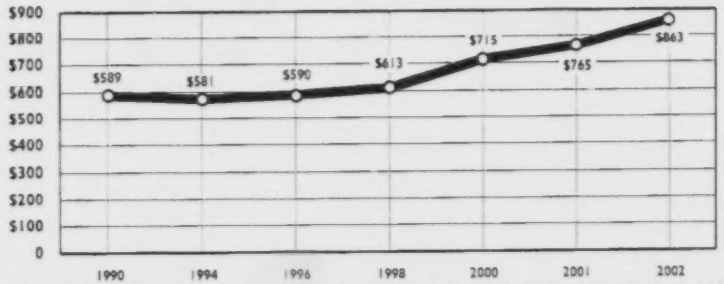
Inadequate, costly or crowded housing has a negative impact on children's health, safety, education and emotional well-being. Nationwide over the last three decades, the percentage of families with a cost burden – that is, paying more than 30% of their income for housing – rose from 15% to 28%. The percentage with severe cost burdens, paying more than half their income for housing, rose from 6% to 11%.[1]

Housing that costs more than one-third of a family's income is considered unaffordable.[2] Families with high housing costs are likely to go without other basic necessities such as food, medicine and clothing in order to pay their rent (or mortgage) and utilities. Severe financial strain can hinder effective parenting, heighten conflict and contribute to the break-up of families.[3] In 2001, there were 4 million working families spending more than 50% of their income on rent in the U.S.[4] Disproportionately large shares of minority and single-parent households spend more than 50% of their income on housing. Nearly one in three minority and single-parent households face severe cost burdens.[5]

It is estimated that 9,900 of Rhode Island's rental units have physical defects. Eighty percent of these are located in urban communities.[6] Common housing problems include roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, plumbing problems and lack of major appliances. A home's physical condition, safety, the level of crowding in a household and the quality of the surrounding neighborhood can all affect child well-being.[7] Research shows that there are strong links between substandard housing and educational disadvantages.[8]

The decline in federal housing subsidies and the growth in income inequality in Rhode Island over the last decade have contributed to the housing crisis for low-income and moderate-income families. Increased income inequality has led to a greater emphasis on high-end housing construction in the suburbs and luxury condominiums in urban areas. Lack of construction of middle-income and low-income units statewide has increased competition for low-income housing, resulting in rising rents for often substandard housing.[9]

Average Rent, Two Bedroom Apartment, Rhode Island, 1990 – 2002



Source: Rhode Island Housing and Mortgage Finance Corporation Annual Rent Surveys. Information not available for 1991, 1992, 1993, 1995, 1997, 1999.

◆ The cost of renting a two-bedroom apartment in Rhode Island increased from $589 a month in 1990 to $863 a month in 2002. Housing prices remain out of reach for many families. A worker would have to earn $15.09 per hour for forty hours per week to be able to afford the average two-bedroom apartment in Rhode Island. This is more than twice the current minimum wage of $6.15 per hour.[10]

Homeownership

◆ During the 1990s, low interest rates and public policies aimed at increasing the homeownership rate nationwide enabled thousands of low-income and moderate-income families to become homeowners for the first time.[11]

◆ Many low-income homeowners face increasingly high housing cost burdens. Between 1989 and 1999, the percentage of Rhode Island households with cost burdens (those paying more than 30% of their household income on housing) increased from 55% to 58% of renters and 41% to 58% of homeowners.[12]

Table 6

Cost of Rental Housing for Low-Income Families, Rhode Island, 2002

CITY/TOWN	2002 AVERAGE MONTHLY RENT 1-BEDROOM	2002 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT, POVERTY LEVEL FAMILY OF THREE	2002 VERY LOW-INCOME RENTER	% INCOME NEEDED FOR RENT, VERY LOW-INCOME RENTER
Barrington	$1,052	$15,020	84%	$28,100	45%
Bristol	$919	$15,020	73%	$28,100	39%
Burrillville	NA	$15,020	NA	$28,100	NA
Central Falls	$682	$15,020	54%	$28,100	29%
Charlestown	$936	$15,020	75%	$28,100	40%
Coventry	$758	$15,020	61%	$28,100	32%
Cranston	$851	$15,020	68%	$28,100	36%
Cumberland	$886	$15,020	71%	$28,100	38%
East Greenwich	$913	$15,020	73%	$28,100	39%
East Providence	$800	$15,020	64%	$28,100	34%
Exeter	NA	$15,020	NA	$28,100	NA
Foster	NA	$15,020	NA	$28,100	NA
Glocester	$817	$15,020	65%	$28,100	35%
Hopkinton	NA	$15,020	NA	$29,950	NA
Jamestown	NA	$15,020	NA	$28,100	NA
Johnston	$817	$15,020	65%	$28,100	35%
Lincoln	$843	$15,020	67%	$28,100	36%
Little Compton	NA	$15,020	NA	$28,100	NA
Middletown	NA	$15,020	NA	$29,050	NA
Narragansett	$1,035	$15,020	83%	$28,100	44%
New Shoreham	NA	$15,020	NA	$29,050	NA
Newport	$1,132	$15,020	90%	$29,050	47%
North Kingstown	$885	$15,020	71%	$28,100	38%
North Providence	$768	$15,020	61%	$28,100	33%
North Smithfield	NA	$15,020	NA	$28,100	NA
Pawtucket	$736	$15,020	59%	$28,100	31%
Portsmouth	NA	$15,020	NA	$29,050	NA
Providence	$884	$15,020	71%	$28,100	38%
Richmond	NA	$15,020	NA	$28,100	NA
Scituate	NA	$15,020	NA	$28,100	NA
Smithfield	$905	$15,020	72%	$28,100	39%
South Kingstown	$889	$15,020	71%	$28,100	38%
Tiverton	NA	$15,020	NA	$28,100	NA
Warren	$828	$15,020	66%	$28,100	35%
Warwick	$841	$15,020	67%	$28,100	36%
West Greenwich	NA	$15,020	NA	$28,100	NA
West Warwick	$799	$15,020	64%	$28,100	34%
Westerly	$844	$15,020	67%	$29,950	34%
Woonsocket	$749	$15,020	60%	$28,100	32%
Core Cities	*$830*	*$15,020*	*66%*	*$28,100*	*35%*
Remainder of State	*$873*	*$15,020*	*70%*	*$28,100*	*37%*
Rhode Island	*$863*	*$15,020*	*69%*	*$28,100*	*37%*

Source of Data for Table/Methodology

Rhode Island Housing and Mortgage Finance Corporation. January-December 2002 Rent Survey and the Department of Housing and Urban Development. Average rents are based on a survey of rents in Rhode Island between January and December 2002. Rents include the HUD allowance for heat, if heat was not included in the advertised rent. A very low-income family is defined by the U.S. Department of Housing and Urban Development as a family with income 50% of the median family income and is calculated separately for Hopkinton, Middletown, New Shoreham, Newport, Portsmouth and Westerly.

References for Indicator

[i] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[ii] *Rental Housing for America's Poor Families: Farther Out of Reach Than Ever* (2002). Washington, DC: National Low-Income Housing Coalition.

[iii] Shore, R. (October 2000). *Our Basic Dream, Keeping Faith with America's Working Families and Their Children*. New York, NY: Foundation for Child Development.

[iv] *America's Working Families and the Housing Landscape 1997-2001* (November 2002). Washington, DC: Center for Housing Policy/National Housing Conference.

[v] *The State of the Nation's Housing 2001* (2001). Cambridge, MA: Joint Center for Housing Research, Harvard University.

[vi] *The State of Rhode Island Consolidated Plan FY 2001 – 2005* (January 2000). Providence, RI: Rhode Island Housing and Mortgage Finance Corporation.

[vii] *Trends in the Well-Being of America's Children and Youth* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Secretary for Planning and Evaluation.

[viii] Rhode Island KIDS COUNT calculations using data from Rhode Island Housing and Mortgage Finance Corporation.

[ix] Hinsch, E. (2001). *Rhode Island's Housing Crisis*. Providence, RI: Providence College.

[x] *The State of the Nation's Housing 2002* (2002). Cambridge, MA: Joint Center for Housing Research, Harvard University.

[xi] U.S. Census Bureau, 1990 and 2000 Census of the Population.

Secure Parental Employment

DEFINITION

Secure parental employment is the percentage of children living with at least one parent who has full-time, year-round employment.

SIGNIFICANCE

Secure parental employment can have positive impacts on child well-being that go beyond reducing poverty and increasing median household income. Children with parents who have steady employment are more likely to have access to health care and stable, regular child care.[1] Secure parental employment is also likely to improve family functioning by reducing the stress brought on by unemployment and underemployment of parents.[2]

In Rhode Island in 2000, there were approximately 75,000 Rhode Island children with no parent working full time, year round.[3] This is almost a third (31%) of all Rhode Island children, slightly higher than the national rate of 28%.[4]

In 2001 the Rhode Island unemployment rate was 4.7%, similar to the national average.[5] Unemployment rates vary significantly across cities and towns in the state, from highs of 10.1% in New Shoreham and 8.5% in Central Falls to lows of 1.8% in Richmond and 2.4% in Narragansett.[6]

The Rhode Island unemployment rate increased to 5.1% in 2002 while the U.S. rate increased to 5.8%.[7,8]

When families work in low-wage jobs, many remain below the poverty level and many more are low income.[9] The likelihood of having one parent with full-time year-round employment and remaining poor has increased in recent years from 22% of poor children in 1990, to 35% of poor children in 2000.[10] Between 1990 and 2000 in Rhode Island, the number of children living in low-income working families (full-time work and income below 200% of the federal poverty line) increased 18%, from 28,000 children to 33,000 children. This is 15% of all Rhode Island children, lower than the national average of 19%.[11]

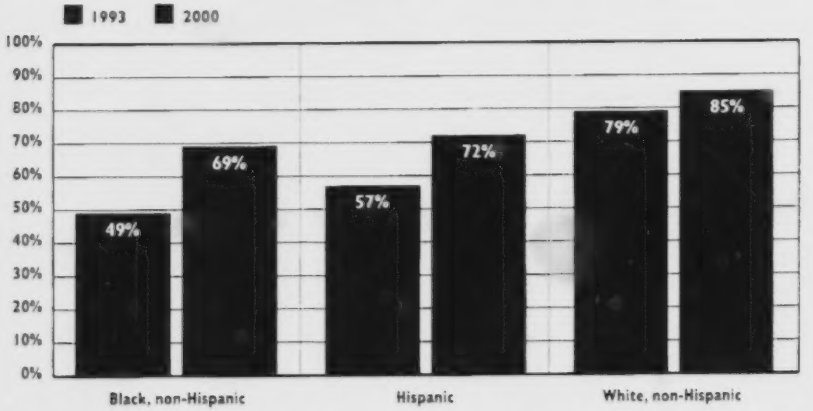
Secure Parental Employment

	1990	2000
RI	70%	69%
US	71%	72%
State Rank		*37th*

1st is best; 50th is worst

Source: *Children At Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Secure Parental Employment by Race and Ethnicity, United States, 1993 and 2000



Note: Secure parental employment is the percentage of children living with at least one parent with full-time, year-round employment.

- Secure parental employment increased for Black, Hispanic and White children between 1993 and 2000.
- Hispanic and Black children in the U.S. continue to be less likely than White, non-Hispanic children to live with at least one parent with full-time, year-round employment.
- Much of the increase in secure parental employment between 1993 and 2000 was due to the increase in the percentage of children living with single mothers who are employed full time year round, which increased from 33% in 1993 to 50% in 2000.
- During the past two decades, the percentage of children living in two-parent families in which both the mother and father worked full time all year has almost doubled, increasing from 17% to 33%.

Source: *America's Children: Key National Indicators of Well-Being* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

Federal and State Tax Credits

◆ The Child Tax Credit (CTC) is a federal tax credit worth up to $600 per child in 2002 for families with children under age 17. The CTC has been in effect since 1998, but recent Congressional changes now make the credit available to more working families and make it refundable, meaning that families can get the credit even if they owe no tax.[12]

◆ The federal Earned Income Tax Credit is a refundable credit on the federal income tax, available since 1975, to low-income and moderate-income working families with children. Five million people, about half of whom are children, were lifted above the poverty line as a result of the federal EITC.[13] In 2001 in Rhode Island, 57,667 low-income working individuals and families received the federal EITC.[14]

◆ The state of Rhode Island is one of sixteen states that have established state EITC programs that can increase the income of low-wage workers to levels above the poverty line. Refundable EITC programs exist in 11 states and maximize economic benefits to the lowest-income families.[15]

◆ Rhode Island's EITC is non-refundable so that it provides no benefits to working families that have income too low to owe state income taxes.[16] When a state EITC is refundable, the family receives a refund check if the size of its EITC exceeds its tax bill. In 2001, families in Rhode Island had no state income tax liability until they reached $25,200.[17]

◆ A refundable state EITC would contribute an additional $14 million to the budgets of low-income working families in the Providence area and $4.7 million to the economy of the City of Providence.[18]

References

[12,13] *America's Children: Key National Indicators of Well-Being* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[14,15] *Children At Risk: State Trends 1990 – 2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[16] Rhode Island Department of Labor and Training, Labor Market Information Division. Unadjusted Unemployment Rates for States Ranked by Annual Average (March 2002). www.dlt.state.ri.us.

[17] Rhode Island Department of Labor and Training, Labor Market Information Division. Rhode Island City/Town 2001 Annual Average Labor Force Statistics (February 2002). www.dlt.state.ri.us.

Increasing Earnings through Wage Laws

◆ In 2003, the Rhode Island minimum wage is $6.15 per hour.[19] A parent working 40 hours per week, 52 weeks per year at minimum wage in Rhode Island would be unable to earn enough to raise a family of three above the federal poverty level.[20]

◆ Living wage proposals are proposals that are directed at a specific workforce and are set at rates higher than minimum wage laws. There are more than 70 jurisdictions in the U.S. including Boston, Los Angeles, Hartford, and New Haven that have passed living wage ordinances.[21]

◆ Providence is the only city in Rhode Island with a current living wage proposal. The proposed ordinance would require the City of Providence, city contractors with more than 25 employees or contracts over $25,000 per year, and employers receiving substantial new tax breaks to pay a minimum of $10.19 per hour and the equivalent of $1.78 per hour for health insurance benefits.[22]

References

[1] Rhode Island Department of Labor and Training, Labor Market Information Division, Local Area Unemployment Statistics. Unemployment Rates for States, Annual Average Rankings, 1998-Present (March 2003). www.dlt.state.ri.us.

[2] U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Unemployment Rate Civilian Labor Force (January 2003). www.bls.gov.

[12] *Facts about the New Child Tax Credit: A Bigger Paycheck Boost for Many Families* (2003). Washington, DC: Center on Budget and Policy Priorities.

[13,15,18] Johnson, N. (December 2001). *A Hand Up: How State Earned Income Tax Credits Help Working Families Escape Poverty in 2001*. Washington, DC: Center on Budget and Policy Priorities.

[14] Center on Budget and Policy Priorities, EIC Participation for Tax Year 2001 by State (January 2003). www.cbpp.org/eic2003/participation.pdf.

[15] Johnson, N. et al (February 2002). *State Income Tax Burdens on Low-Income Families in 2001*. Washington, DC: Center on Budget and Policy Priorities

[18] *Rewarding Work: The Impact of the Earned Income Tax Credit in Greater Providence* (June 2001). Washington, DC: The Brookings Institute, Center on Urban and Metropolitan Policy.

[19] U.S. Department of Labor, Minimum Wage Laws in the States (January 2003). www.dol.gov/dol/esa/public/minwage/america/htm.

[20] The 2002 Poverty Guidelines, U.S. Department of Health and Human Services (January 2003). http://aspe.hhs.gov/poverty/02.htm.

[21] Economic Policy Institute, Living Wage Ordinances Currently in Place (January 2003). www.epinet.org.

[22] Employment Policies Institute (January 2003). www.livingwage.com.

Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of non-custodial parents in the Rhode Island Child Support Enforcement System who pay child support on time and in full. The percentage does not include cases in which paternity has not been established. Court orders for child support require establishment of paternity.

SIGNIFICANCE

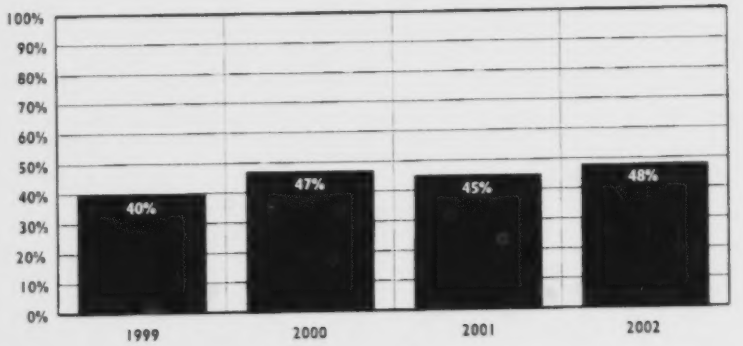
The receipt of child support payments can significantly improve the economic status of a child growing up in a family with a non-resident parent. Child support lifts a half million children from poverty in the U.S. each year.[1] When poor families receive child support, the child support averages 26% of the family's budget - making it the second largest source of income next to earnings.[2]

The goal of the child support system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up. For child support to be collected on behalf of a child, the non-custodial parent must be identified, paternity must be established, a support order must be entered, and the money must be collected.[3] The failure of a non-custodial parent to pay child support has significant economic consequences for the custodial parent and for the child. Nationally, children who live with a custodial parent who do not receive child support payments are more than twice as likely to live in poverty as children whose families receive child support payments in full.[4]

Even when there is a child support order in place, child support payments tend to be low and unreliable. As of December 2002, there were 96,088 Rhode Island children in the State's Child Support Enforcement System.[5] Of these, 24,392 (25%) had not yet had paternity established and therefore were not yet eligible for a child support award.[6] In 2002 in Rhode Island, 48% of Rhode Island non-custodial parents under court order paid child support on time and in full.[7] As of December 31, 2002, the amount of past due court-ordered child support in Rhode Island totaled $175 million.[8]

Although poor fathers are much less likely to pay child support, for every poor father who does not pay child support, there are nearly two non-poor fathers who do not pay.[9] Parents who have regular contact with their children are more likely to pay child support.[10] In 1999 in the United States, 79% of parents who had either joint custody or visitation privileges paid child support compared to 46% who did not have regular contact.

Non-custodial Parents with Court Orders who Pay Child Support On-Time and In Full, Rhode Island 1999 – 2002



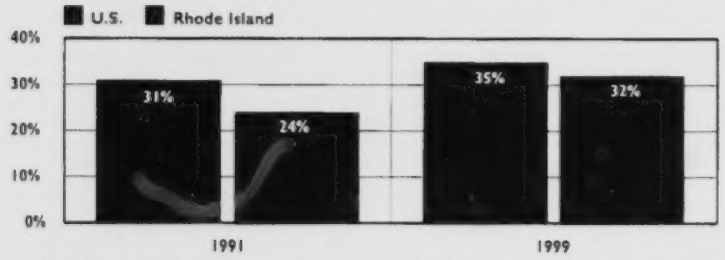
Source: Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, 1999 - 2002

◆ In 2002 in Rhode Island, 48% of custodial parents under court order paid child support on time and in full. This is an increase from 40% in 1999.[12]

◆ Nationally, among the parents with child support agreements, only 45% received all of their child support payments. One in four parents (29%) with agreements received some, but not, all of what was due.[13]

◆ In the U.S., low-income mothers, Black or Hispanic mothers, never-married mothers, and mothers with less than a college education are least likely to receive the child support due under court order.[14]

Female-Headed Families Receiving Child Support or Alimony 1991 and 1999, U.S. and Rhode Island, 1991 and 1999



Source: *KIDS COUNT Databook: State Trends in the Well-Being of Children (1994 and 2002).* Baltimore, MD: The Annie E. Casey Foundation.

◆ In Rhode Island in 2000, 54,648 children lived in a household headed by a single mother.[13] Of the Rhode Island families headed by a single female, 32% received child support or alimony payments in 1999, compared to 35% nationally.[14]

◆ The rate of receipt of child support or alimony in families headed by a single female has increased significantly in Rhode Island since 1991 when only 24% of families received this income.[17]

◆ Reasons that parents do not have legal court orders in place include not feeling the need to make agreements legal, knowing that the other parent could not afford to pay and not wanting to have contact with the other parent.[18] Nationally, 59% of custodial parents had child support agreements in 2000.[19]

Child Support and the Family Independence Program

◆ In order to receive cash benefits through the Family Independence Program (FIP), custodial parents are required to cooperate with the Rhode Island Department of Administration's Child Support Enforcement Division in establishing paternity and seeking child support.[20]

◆ In certain instances, such as domestic violence, the requirement to establish paternity and seek child support may be waived in order to protect the custodial parent. Caseworkers are required to notify FIP applicants and recipients of this waiver option.[21]

◆ In Rhode Island as of December 2002, 55% (15,127) of the 27,522 children enrolled in the Family Independence Program were in the Child Support Enforcement System and had paternity established.[22]

◆ In 2002, the average child support obligation to children enrolled in FIP was $270 per month, as compared to an average child support obligation of $377 per month for non-FIP families.[23] This is a significant increase since 1999 when average obligations were $207 and $237 per month respectively.[24]

◆ An average of 2,958 Rhode Island families enrolled in FIP each month received the $50 child support pass-through in 2002.[25] The first $50 of child support paid on time on behalf of a child receiving cash assistance goes to the custodial parent caring for the child and the remainder goes to the state. Although budget cuts threatened the continued existence of this program, the child support pass-through was maintained in the 2002 legislative session as an important part of the Family Independence Program.[26]

References for Indicator

[1] Sorenson, E. and Zibman, C. (March 2000). *Child Support Offers Some Protection Against Poverty.* Washington, DC: The Urban Institute.

[2] Turetsky, V. (May 2001). *Families Participating in the State Child Support Program.* Washington, DC: Center for Law and Social Policy, Inc.

[3,20] *Giving Hope and Support to America's Children: Handbook on Child Support Enforcement* (1997). Washington, DC: U.S. Department of Human Services, Administration for Children and Families Office of Child Support Enforcement.

[4,5,6,7,8,9] *Custodial Mothers and Fathers and Their Child Support: 1999* (October 2002). Washington, DC: U.S. Census Bureau.

[10,11,12,22,23] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 1, 2002.

[13] Sorenson, E. and Zibman, C. (April 2001). *Poor Dads Who Don't Pay Child Support: Deadbeats or Disadvantaged?* Washington, DC: The Urban Institute.

[14] Koball, H. and Principe, D. (March 2002). *Do Non-resident Fathers Who Pay Child Support Visit Their Children More?* Washington, DC: The Urban Institute.

[15] U.S. Bureau of the Census, Census 2000.

[16] *KIDS Count Data Book: State Profiles of Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[17] *KIDS Count Data Book: State Profiles of Child Well-Being 1994* (1994). Baltimore, MD: The Annie E. Casey Foundation.

[21] *Paternity: Questions Moms Usually Ask and Their Answers.* Providence, RI: State of Rhode Island and Providence Plantations.

[24] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 2002, and the Rhode Island Department of Human Services InRhodes Database, December 2002.

[25] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 1, 1999.

[26] *Legislative Wrap-Up: 2002 Session of the Rhode Island General Assembly* (August 2002). Providence, RI: Rhode Island KIDS COUNT.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

Poverty is related to every KIDS COUNT indicator. Children in poverty, especially those in poverty for extended periods of time, are more likely to have health and behavioral problems, experience difficulty in school, become teen parents and to earn less as adults.[1,2] Children in low-income communities are more likely to attend poorly equipped schools; have less access to libraries and cultural activities; have limited access to high quality child care programs; and have fewer opportunities to participate in sports and recreations programs after school and in the summer.[3,4]

Children of color and children of immigrants are more likely to grow up poor.[5,6] Single parenthood, low educational attainment, part-time or no employment and low wages of parents place children at risk of being poor.[7,8]

Family economic conditions in early and middle childhood appear to be more important for shaping ability and achievement than do economic conditions during adolescence.[9] Efforts that improve the quality of a child's environment and increase family income in the early years of life will improve the likelihood of healthy child development.[10]

There is considerable movement into and out of poverty each year.[11] Low-income working families often must choose between the demands of work and the needs of raising children without the supports available to higher income families.[12] For these families, the margin of income to expenses makes it difficult to build an asset base to cushion against falling back into poverty in tough times.[13]

According to the Census, in 2000 there were 40,117 children living in poverty in Rhode Island, 16.5% of all children in the state.[14] The 2002 poverty threshold for a family of three with two children is $14,494.[15]

Children in Poverty

	1990	2000
RI	14%	17%
US	18%	17%
State Rank		*30th*

1st is best; 50th is worst

Source: *Children at Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Rhode Island's Poor Children, 2000

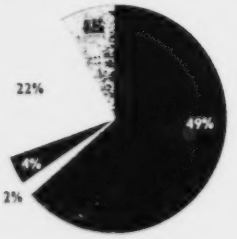
By Age

35%	Ages 5 and younger
37%	Ages 6 to 11
28%	Ages 12 to 17

n = 41,162 (includes unrelated children living in households)

By Race*

49%	White
14%	Black
2%	Asian
4%	American Indian
22%	Some Other Race
8%	Two or More Races



n = 40,117

By Family Structure*

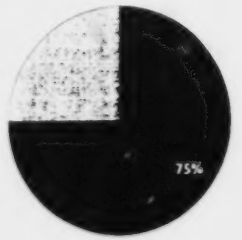
23%	Married Couple Family
7%	Male Householder Only
70%	Female Householder Only

n = 40,177

**Hispanic children may be included in any race category. Of Rhode Island's 40,117 poor children, 15,750 (39%) are Hispanic.*

By Residence

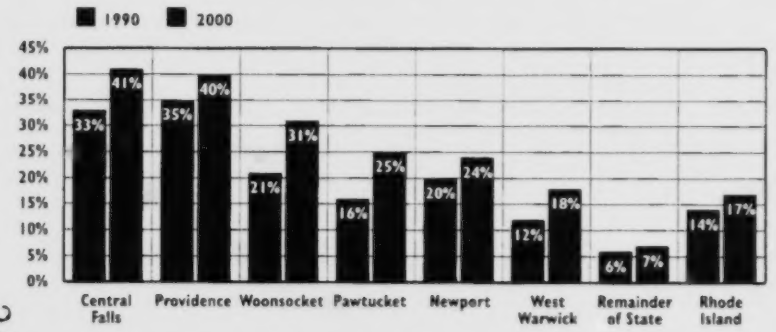
75%	Core Cities
25%	Remainder of State



n = 40,177

Source: U.S. Bureau of the Census, Census 2000. Except where otherwise noted, population includes related children under age 18, who are living in households for whom poverty status was determined and are somehow related to the householder. This could include nieces, nephews, step children, adopted children, etc.

Child Poverty Rates, 1990 and 2000, Core Cities, Remainder of State and Rhode Island



Source: U.S. Census Bureau, 1990 and 2000 Census of the Population

◆ Rhode Island's child poverty rate increased from 14% to 17% over the decade of the 1990s. The child poverty rate increased in each of the core cities between 1990 and 2000. For the core cities overall, the child poverty rate increased from 26% to 33% during the 1990s, even as it remained relatively stable at 6% to 7% in the remainder of the state.[16]

◆ Rhode Island KIDS COUNT defines core cities as those communities in which 15% or more of the children live in families with income below the federal poverty threshold. Three-quarters (75%) of Rhode Island's poor children live in one of the six core cities.[17]

◆ Because of increases in child poverty between 1990 and 2000, West Warwick is now a core city with 18% of children living in poverty.[18] Providence now has the third highest child poverty rate (40%) in the country among cities with a population of 100,000 or more.[19] Central Falls has the highest child poverty rate (41%) of any city or town in Rhode Island.[20]

Children Living in Extreme Poverty

◆ Families with income below 50% of the federal poverty level are considered to be living in extreme poverty.[21] The extreme poverty level in 2002 is family income below $9,122 for a family of four.[22]

◆ Children who live in deep, long-term poverty experience the worst outcomes as a result of their family's income status.[23] In 2000, 19,773 children in Rhode Island lived in extreme poverty. This is 8% of all Rhode Island children and half of all poor children in Rhode Island.[24]

Young Children Under Age 6 in Poverty in Rhode Island

◆ Research shows that young children who live in poverty are more likely to have impaired development because of their increased exposure to risk factors associated with poverty including: inadequate nutrition, environmental toxins, maternal depression, trauma and abuse, lower quality child care and parental substance abuse.[25]

◆ In 2000, 19% (14,548) Rhode Island children under 6 were living in poverty, compared to 17% nationally.[26,27] Of these children, 7,230 were extremely poor.[28]

◆ As of December 1, 2002, there were 5,909 children under age 3 and 5,097 children ages 3 to 5 in families receiving cash assistance from the Family Independence Program. Of all children in the Family Independence Program, 40% are under age 6.[29]

Children in Poverty

Children in Low-Income Families, Rhode Island, 2000

Annual Income	% of Poverty Threshold	#	%
Under $9,122	Under 50%	19,773	8%
$9,122 - $18,243	50% - 99%	21,389	9%
$18,244 - $27,365	100% - 149%	20,932	9%
$27,366 - $36,487	150% - 199%	21,326	9%
Total Income Below 200%		83,420	35%

n=243,838

Source: U.S. Census Bureau, Census 2000. Income amounts are calculated for a family of four with two children. The poverty threshold in 2002 for a family of four with two children was $18,244.

◆ More than one in three children (35%) in Rhode Island live in a low-income family with income below 200% of the poverty threshold. The federal poverty threshold is an underestimate of the number of families with children in Rhode Island who are unable to meet their basic needs for food, shelter and other necessities.[30]

◆ The Rhode Island Standard of Need considers the costs of housing, child care and health care as well as the cash value of tax credits and income support programs. Due to child care and health care subsidies, a family making about 150% of poverty is able to make ends meet. If the family earns more than 225% of the federal poverty threshold, they become ineligible for child care subsidies and expenses begin to exceed income.[31]

35

Building Blocks of Economic Security

Income Supports

◆ Income support includes: the FIP Earned Income Disregard, Food Stamps, the Earned Income Tax Credit, and Energy Assistance programs. Income supports help to ensure that low-income working families have adequate resources to meet their basic needs.[32]

Access to Health Care

◆ Many workers in low-wage jobs are often not offered affordable employer-sponsored health insurance. Access to health insurance improves the likelihood of having a regular and affordable source of health care.[33]

Affordable Quality Child Care

◆ The quality and stability of the child care setting is critical to a parent's ability to work and to the child's development.[34] Child care costs represent a significant part of the budget of low-income families and are associated with a mother's refusal or termination of employment.[35]

Affordable Housing

◆ Stable housing is a critical requirement for job retention and performance.[36] In 2002, the average rent for a two-bedroom apartment in Rhode Island is $863, more than double the amount that is considered affordable for a family of three with income below the poverty level.[37]

Educational Attainment

◆ Individuals with higher education generally have more job opportunities, higher wages and greater job security than those with lower levels of education.[38]

Table 7.

Child Poverty, Rhode Island, 2000

CITY/TOWN	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY	
	N	%	N	%	N%	%
Barrington	56	2.3%	23	1.9%	116	2.5%
Bristol	216	8.7%	157	11.4%	396	9.2%
Burrillville	106	5.0%	80	7.9%	236	6.0%
Central Falls	988	34.6%	740	42.7%	2,189	40.8%
Charlestown	42	4.2%	18	3.7%	78	4.7%
Coventry	232	5.1%	149	6.4%	455	5.6%
Cranston	794	8.4%	437	8.6%	1,417	8.6%
Cumberland	162	3.8%	89	3.6%	237	3.1%
East Greenwich	65	3.6%	57	6.1%	147	4.1%
East Providence	613	10.2%	452	14.5%	1,109	10.7%
Exeter	49	5.6%	69	16.3%	112	7.5%
Foster	18	3.1%	-	0.0%	32	2.9%
Glocester	76	5.2%	37	5.7%	171	6.4%
Hopkinton	64	5.5%	55	8.9%	107	5.5%
Jamestown	9	1.3%	-	0.0%	17	1.4%
Johnston	287	8.2%	183	9.5%	527	9.0%
Lincoln	178	6.3%	76	5.6%	316	6.2%
Little Compton	8	1.9%	8	3.5%	8	1.0%
Middletown	161	6.7%	70	5.0%	264	6.2%
Narragansett	133	7.8%	50	6.5%	230	8.4%
New Shoreham	14	13.0%	3	4.8%	19	10.2%
Newport	654	22.4%	628	34.3%	1,223	23.8%
North Kingstown	362	9.4%	239	11.1%	657	9.6%
North Providence	327	9.0%	212	12.0%	559	9.8%
North Smithfield	38	2.9%	45	6.3%	67	2.8%
Pawtucket	2,229	22.7%	1,711	29.2%	4,353	24.5%
Portsmouth	65	2.8%	63	5.0%	118	2.8%
Providence	7,651	34.3%	6,137	42.5%	17,714	40.1%
Richmond	38	3.4%	17	2.4%	82	4.2%
Scituate	52	3.7%	30	4.2%	113	4.3%
Smithfield	85	3.7%	11	1.0%	153	3.9%
South Kingstown	166	5.0%	82	4.6%	297	4.9%
Tiverton	62	3.2%	48	5.4%	90	2.7%
Warren	104	7.3%	60	7.6%	198	8.1%
Warwick	642	6.1%	386	6.8%	1,175	6.4%
West Greenwich	7	0.9%	18	3.7%	40	2.7%
West Warwick	604	16.1%	606	26.8%	1,170	17.9%
Westerly	204	7.0%	141	8.0%	512	9.6%
Woonsocket	1,581	26.8%	1,361	35.0%	3,413	31.3%
Core Cities	*13,707*	*28.8%*	*11,183*	*37.3%*	*30,062*	*33.4%*
Remainder of State	*5,435*	*6.3%*	*3,365*	*8.0%*	*10,055*	*6.6%*
Rhode Island	*19,142*	*14.2%*	*14,548*	*20.2%*	*40,117*	*16.5%*

Source of Data for Table/Methodology

Data are from the U.S. Bureau of the Census, Census 2000.

References for Indicator

[1,2] *America's Children: Key Indicators of Well Being* (2002). Washington, DC: U.S. Federal Interagency Forum on Child and Family Statistics.

[2,23] Moore, K. et. al. (November 2002). *Children in Poverty: Trends, Consequences, and Policy Options.* Washington, DC: Child Trends.

[3,24] *Years of Promise: A Comprehensive Strategy for America's Children* (1996). New York, NY: Carnegie Corporation.

[4] Jargowsky, P. (1997). *Poverty and Place: Ghettos, Barrios and the American City.* New York, NY: Russell Sage Foundation.

[5,7] Children's Defense Fund. *Child Poverty: Characteristics of Poor Children in America – 2000.* www.childrensdefense.org, February 2003.

[6] *Children of Immigrants: A Statistical Profile* (September 2002). New York, NY: National Center for Children in Poverty.

[8,18] *Poverty in the United States: 2001* (September 2002). Washington, DC: U.S. Census Bureau.

[9] Duncan G.J. et al (1997). "Longitudinal Indicators of Children's Poverty and Dependence" in Hauser, R. et. al. (eds.) *Indicators of Children's Well-Being.* New York, NY: Russell Sage Foundation.

[10,11] *From Neurons to Neighborhoods: The Science of Early Childhood Development* (2000). Washington, DC: National Academy Press.

[12,13,21,22] *KIDS COUNT Databook* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[14,15,17,19,20,25,26] U.S. Census Bureau, Census 2000.

[16,27] U.S. Census Bureau, "Thresholds for 2002 by Size of Family and Number of Related Children Under 18 Years, www.census.gov., February 2003.

continued on page 126

Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 2002. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 2002.

SIGNIFICANCE

Rhode Island's Family Independence Program (FIP) seeks to help families make successful transitions to work by providing the cash assistance and work supports, including health insurance and subsidized child care, that families need to obtain and keep a job. In addition, the program provides a safety net for children living in families with adults who are unable to work.[1] There are currently 893 families enrolled in FIP who are unable to work due to illness or advanced age and 2,237 who are exempt from work because they are in their third trimester of pregnancy or have children under age one.[2] If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month.[3] The FIP monthly payment has not increased in 13 years.[4] With an additional $350 per month in Food Stamps, this income is 75% of the federal poverty threshold and well below the amount of income families need to pay basic living expenses.[5]

More than two-thirds (69%) of all FIP beneficiaries are children under the age of 18.[6] Four of every five children receiving cash assistance through FIP are ages 12 and under.[7] As of December 2002, there were 3,081 FIP child-only cases.[8] Child-only cases are those that receive cash assistance only for the children in the family because the child is living with a grandparent or other non-parent relative, the parent has reached their five-year time limit, the parent is disabled and receiving Supplemental Security Income or the parent is not a U.S. citizen.[9] Child-only cases have increased from 12% of all cases in May 1996 to 21% of all cases in December 2002.[10,11] The percentage of all cases that are child-only cases will continue to increase as adults in the family reach five-year time limits. As of January 2003, 293 adults have reached their time limits.[12]

Since the start of the latest economic recession in March 2001, Rhode Island is one of the few states that continues to see welfare caseloads decline.[13] As of December 1, 2002, there were 40,068 adults and children in Rhode Island enrolled in the Family Independence program.[14]

Work Supports

◆ As of December 1, 2002 in Rhode Island, 2,625 (23%) of the adults receiving FIP cash assistance were employed at an average wage of $7.89 per hour.[16] The program provides work incentives by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated.[16]

◆ Income supports including RIte Care, child care subsidies, cash assistance, Food Stamps and the Earned Income Tax Credit are critical to the well-being of low-income working families with insufficient income to meet all their needs.

◆ The Rhode Island Standard of Need, developed by the Poverty Institute at Rhode Island College, approximates the income a family needs to pay for basic living expenses. With the benefit of state and federal work supports, the Rhode Island Standard of Need for a single parent with two children is $10.55 compared to $19.51 without these programs.[17]

Education and Training

◆ There is evidence in Rhode Island and nationally that families still receiving cash assistance generally have more serious barriers to employment than those who have left assistance.[18,19] Adults remaining on FIP are more likely to face barriers to employment because they have low literacy levels, do not have at least a high school diploma, and do not speak English as a first language.[20]

◆ The Family Independence Program (FIP) permits adults receiving cash assistance to get necessary education or basic skills training for up to 24 months before beginning work. Evaluations of FIP have found that adults who opted for training or education before they looked for jobs were far more likely to be employed and had family earnings higher than before the training.[21,22]

Table 8.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 2002

CITY/TOWN	All children under 18	Number receiving FIP cash assistance: Families	Number receiving FIP cash assistance: Children	FIP children as % of all children under 18
Barrington	4,745	15	23	<1%
Bristol	4,399	92	152	3%
Burrillville	4,043	77	117	3%
Central Falls	5,531	778	1570	28%
Charlestown	1,712	34	57	3%
Coventry	8,389	174	253	3%
Cranston	17,098	587	970	6%
Cumberland	7,690	101	161	2%
East Greenwich	3,564	46	68	2%
East Providence	10,546	395	638	6%
Exeter	1,589	25	43	3%
Foster	1,105	14	20	2%
Glocester	2,664	26	44	2%
Hopkinton	2,011	20	33	2%
Jamestown	1,238	13	23	2%
Johnston	5,906	204	328	6%
Lincoln	5,157	75	138	3%
Little Compton	780	9	14	2%
Middletown	4,328	64	100	2%
Narragansett	2,833	51	81	3%
New Shoreham	185	0	0	0%
Newport	5,199	459	937	18%
North Kingstown	6,848	151	241	4%
North Providence	5,936	237	382	6%
North Smithfield	2,379	25	39	2%
Pawtucket	18,151	1681	3014	17%
Portsmouth	4,329	32	50	1%
Providence	45,277	6851	13753	30%
Richmond	2,014	21	36	2%
Scituate	2,635	31	42	2%
Smithfield	4,019	33	54	1%
South Kingstown	6,284	114	217	3%
Tiverton	3,367	75	110	3%
Warren	2,454	74	138	6%
Warwick	18,780	460	755	4%
West Greenwich	1,444	19	24	2%
West Warwick	6,632	325	550	8%
Westerly	5,406	142	256	5%
Woonsocket	11,155	1098	2091	19%
Core Cities	*91,945*	*11,192*	*21,915*	*24%*
Remainder of State	*155,877*	*3,436*	*5,607*	*4%*
Rhode Island	*247,822*	*14,628*	*27,522*	*11%*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 2002. The denominator is the total number of children under age 18 from Census 2000.

Core Cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1,3] *Rhode Island's Family Independence Program, Annual Report.* (2001). Cranston, RI: Rhode Island Department of Human Services.

[2,4,5,6,7,8,9,10] Rhode Island Department of Human Services, INRHODES Database, December 1, 2002.

[11] Rhode Island Department of Human Services, INRHODES Database. Calculations by Rhode Island KIDS COUNT.

[12] Rhode Island Department of Human Services, INRHODES Database, May 1996.

[13] Richer, E. et. al. (December 30, 2002) *Welfare Caseloads Increase in Most States in Third Quarter, National Caseload Also Up.* Washington, DC: Center for Law and Social Policy.

[14] *The 2001 Rhode Island Standard of Need* (May 2002). Providence, RI: The Poverty Institute at Rhode Island College School of Social Work.

[15,21] "Comments to the U.S. Department of Health and Human Services Regarding the Reauthorization of the TANF Block Grant" (November 2001). Washington, DC: Center for Law and Social Policy.

[16,22] Witte, A.D. and Queralt, M. (August 2001). *Study of The Cash Assistance Program May 1996 – April 2000.* Wellesley, MA: Wellesley College.

[17] A &M Consulting (February 2002). *Rhode Island's Family Independence Act: Research Demonstrates Wisdom of Putting Families First.* Cranston: RI Department of Human Services.

[18] Bromley, M.A. (October 2002). *Rhode Island College Welfare Reform Evaluation Project: Rhode Island Family Independence Program Longitudinal Study.* Providence, RI: Rhode Island College School of Social Work.

Children Receiving Food Stamps

DEFINITION

Children receiving Food Stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

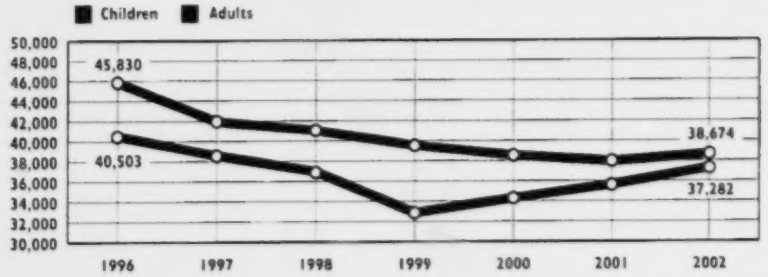
The Food Stamp Program provides low-income families with the ability to obtain better nutrition through monthly benefits that can be used to purchase food at retail stores.[1] Research shows that hunger and lack of regular access to sufficient food are linked to serious health, psychological, emotional and academic problems in children and can impede their healthy growth and development.[2]

The Food Stamp Program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. Food Stamp benefits are not time-limited and can be used as long as the person maintains their certification.[3,4] One of the strengths of the Food Stamp Program is its flexibility. The program is structured to respond to changes in need brought on by economic cycles or natural emergencies.[5] Many working families are unaware of their eligibility for Food Stamps. The benefit level for each eligible household is adjusted according to income. The monthly benefit level decreases as household income increases.[6] Nearly one in five (19%) Food Stamp cases in Rhode Island has some earned income.[7]

To qualify for Food Stamps, a household's gross income must be less than 130% of the federal poverty level for that family size and meet requirements that limit the value of assets (such as cash and automobiles).[8] For example, a family of four with a gross annual income less than $23,532 (monthly income less than $1,961) will qualify for Food Stamps if they meet the assets guidelines.[9]

The maximum monthly Food Stamp benefit for a Rhode Island family of three is $366. This is $10 higher than last year's maximum. The average monthly benefit for family of three in the state is $226, a decrease from the 1997 monthly average of $270.[10] As of October 1, 2002 there were 39,717 children in Rhode Island who were receiving benefits from the Food Stamp Program. Half of all Food Stamp recipients in Rhode Island are children under age 18.[11]

Food Stamp Participation, Children under Age 18 and Adults, Rhode Island, 1996-2002



Source: Rhode Island Department of Human Services, INRHODES Database, 1996 – 2002. Data represents children and adults as of December 1st of each year.

◆ The number of children participating in the Food Stamp Program declined from 45,830 in 1996 to to 38,674 in 2002, a 16% decrease. During the same time period, the number of adults on the Food Stamp Program decreased from 40,503 to 37,282, an 8% decrease.

◆ The USDA estimates that only 59% of those eligible for Food Stamps in the United States were enrolled in 2000. In Rhode Island, the USDA estimates that between 59% and 72% of people who were eligible for the Food Stamp Program participated in 2000.[12]

◆ Based on Census 2000 estimates of the number of children ages birth to 18 living in families with incomes below 130% of the federal poverty limit, there are an estimated 53,697 children eligible to participate in the Food Stamp Program in Rhode Island. As of October 1, 2002, 74% (39,717) were participating.[13]

◆ Participation rates vary across the state. Overall, low-income children in the core cities are more likely to receive Food Stamps, with 80% of income-eligible children participating. This compares to 59% of eligible children participating in the remainder of the state.[14]

Table 9. **Children Under Age 18 Receiving Food Stamps, Rhode Island, October 1, 2002**

CITY/TOWN	ESTIMATED NUMBER INCOME-ELIGIBLE	NUMBER PARTICIPATING	% OF INCOME-ELIGIBLE PARTICIPATING
Barrington	155	40	26%
Bristol	607	227	37%
Burrillville	356	225	63%
Central Falls	2,840	2,240	79%
Charlestown	173	88	51%
Coventry	654	414	63%
Cranston	2,057	1,447	70%
Cumberland	485	256	53%
East Greenwich	242	118	49%
East Providence	1,687	1,075	64%
Exeter	169	92	54%
Foster	66	39	59%
Glocester	225	75	33%
Hopkinton	228	78	34%
Jamestown	36	17	47%
Johnston	733	496	68%
Lincoln	404	197	49%
Little Compton	21	16	76%
Middletown	404	153	38%
Narragansett	310	121	39%
New Shoreham	19	0	0%
Newport	1,731	1,275	74%
North Kingstown	818	429	52%
North Providence	802	515	64%
North Smithfield	92	46	50%
Pawtucket	5,948	4,508	76%
Portsmouth	187	81	43%
Providence	22,395	18,960	85%
Richmond	118	81	69%
Scituate	157	60	38%
Smithfield	239	109	46%
South Kingstown	485	311	64%
Tiverton	150	151	100%
Warren	333	220	66%
Warwick	1,712	1,211	71%
West Greenwich	81	35	43%
West Warwick	1,610	847	53%
Westerly	843	442	52%
Woonsocket	4,125	3,022	73%
Core Cities	*38,649*	*30,852*	*80%*
Remainder of State	*15,048*	*8,865*	*59%*
Rhode Island	*53,697*	*39,717*	*74%*

Note to Table

Because of a change in methodology, Food Stamp participation rates in this Factbook cannot be compared with previous Factbooks. This year's estimates for the percentage of eligible participating in the Food Stamp Program in Rhode Island cities and towns are based on the total number of children ages birth to 18 living in families with incomes below 130% of the federal poverty level according to the 2000 Census. Past estimates were based on the percent of children eligible for the free school meals program. Some children who are eligible for free school meals may not be eligible for Food Stamps because they do not meet other program requirements.

Source of Data for Table/Methodology

Estimated number eligible is based on the total number of children ages birth to 18 living in families with incomes below 130% of poverty according to the 2000 Census. Food Stamp Program participation data are from the Rhode Island Department of Human Services, INRHODES Database, October 1, 2002. Note: October 1st data has been substituted for December 1st data to avoid including participation numbers that may be misrepresented due to early issuance for the holidays. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1,2,3] *The Poverty Institute Guide to Government Assistance Programs 2001* (September 2001). Providence, RI: The Poverty Institute at Rhode Island College School of Social Work.

[2] *The Consequences of Hunger and Food Insecurity for Children: Evidence from Recent Scientific Studies* (June 2002). Waltham, MA: The Center on Hunger and Poverty at Brandeis University.

[3] *Hunger in America: America's Second Harvest's Third National Hunger Study* (2001). Washington, DC: America's Second Harvest.

[3] Food Research and Action Center. Food Stamp Program: Basic Facts and Data. www.frac.org (January 2002).

[4] *The Decline in Food Stamp Participation: A Report to Congress* (July 2001). Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service.

[1,2,3,5] Rhode Island Department of Human Services. INRHODES Database, October 1, 2002.

[6] Food Research Action Center, Food Stamp Program Fiscal Year 2003 Eligibility Limits. www.frac.org (January 2003).

[7] Schirm, A. (December 2002). *Reaching Those in Need: State Food Stamp Participation Rates in 2000*. Washington, DC: USDA and Mathematica Policy Research, Inc.

[1,2] Rhode Island KIDS COUNT calculations based on U.S. Bureau of the Census, Census 2000 and Rhode Island Department of Human Services INRHODES database.

[8] *State Government Responses to the Food Assistance Gap* (2000). Washington, DC: Food Research and Action Center and America's Second Harvest.

[9] U.S. Department of Agriculture Food and Nutrition Service, *Food Stamp Program: New Guidance on Non-Citizen Eligibility*. www.fns.usda.gov (January 2003).

Children Participating in School Breakfast

DEFINITION

Children participating in school breakfast is the percentage of low-income public school children who participate in the School Breakfast Program. Children are counted as low-income if they are eligible for and enrolled in the free or reduced price lunch program.

SIGNIFICANCE

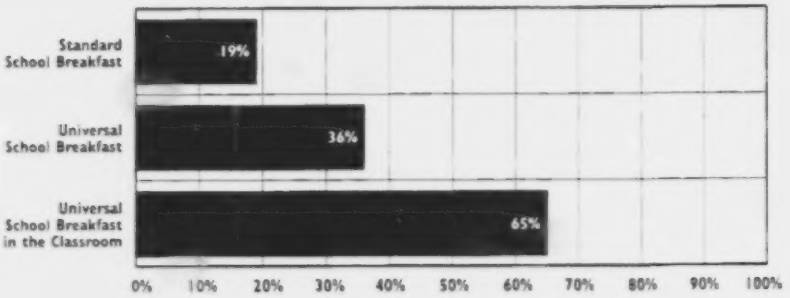
Children who suffer from undernourishment have poorer overall health status than well-nourished children, miss more days of school and are less ready to learn when they do attend.[1] Students who eat breakfast have significantly higher math and reading scores, fewer absences, improved attentiveness and lower incidences of social and behavioral problems.[2]

Low-income students are more likely than other students to arrive at school without an adequate breakfast.[3] Research shows that when school breakfast is available, low-income students are significantly more likely to consume a breakfast than if there was no breakfast program.[4]

In Rhode Island, one in three households with children did not have enough food to meet basic needs at all times during the year in 2000.[5] Rhode Islanders who are Hispanic, have children under the age of 6, are single parents or have not finished high school are the most likely to report that they did not have enough food to meet their basic needs.[6] For other children, long commute times and rushed family schedules make having time for eating breakfast before school difficult and put children at a disadvantage in their ability to concentrate and arrive in class ready to learn.[7]

In 1995, almost two-thirds (62%) of Rhode Island public schools did not offer the breakfast program.[8] Rhode Island state law now requires all public schools to provide students with access to school breakfast.[9] Federal and state funds are available to support the costs of the School Breakfast Program. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals.[10] In October 2002, an average of 17,391 breakfasts were served daily across Rhode Island. Of these, 88% were provided to low-income children eligible for free or reduced price meals.[11]

Participation Rates in the School Breakfast for Three Different Program Models



◆ Universal School Breakfast Programs offer school breakfast free to all students, regardless of family income. Universal programs increase school breakfast participation dramatically, especially among low-income students. When schools offer breakfast in the classroom at the start of the school day, participation increases three-fold.[12]

Source: *Evaluation of the Universal School Breakfast Program Pilot Project: Key Interim Report Findings from the First Year of Implementation* (November 2002). Washington, DC: U.S. Department of Agriculture

◆ Providing free school breakfast to all students can significantly improve the number of low-income children who access the program by removing the stigma that arises when the program is only offered to low-income students. Schools save money by providing universal free breakfast through the elimination of paperwork and increased economies of scale as the total number of breakfast served increases.[13]

◆ Rhode Island ranks 33rd in the country for participation in school breakfast by low-income students. In Rhode Island, there are only 37 low-income students participating in school breakfast for every 100 low-income students participating in school lunch.[14]

◆ In the 2002-2003 school year, Cranston joined Central Falls and Providence as the third school district in the state to offer a Universal School Breakfast program free to every student in the public schools. Efforts are currently underway to develop Universal School Breakfast programs in the remaining core cities.[15]

Table 10.

Children Participating in School Breakfast, Rhode Island, Fall 2002

SCHOOL DISTRICT	2001 FALL ENROLLMENT	DISTRICT WIDE AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL CHILDREN PARTICIPATING IN BREAKFAST	NUMBER OF LOW-INCOME STUDENTS	LOW-INCOME AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL LOW-INCOME CHILDREN PARTICIPATING IN SCHOOL BREAKFAST
Barrington	3,177	9	<1%	81	2	2%
Bristol-Warren	3,664	188	5%	963	151	16%
Burrillville	2,661	112	4%	531	66	12%
Central Falls	3,638	1,088	30%	2,937	858	29%
Chariho	3,718	73	2%	507	54	11%
Coventry	5,585	325	6%	722	166	23%
Cranston	10,737	1,465	14%	2,152	700	33%
Cumberland	5,128	259	5%	655	171	26%
East Greenwich	2,362	47	2%	128	27	21%
East Providence	6,363	447	7%	1,888	395	21%
Exeter-W. Greenwich	2,126	60	3%	202	31	15%
Foster	374	51	14%	55	27	49%
Foster-Glocester	1,632	48	3%	145	20	14%
Glocester	751	6	1%	95	5	5%
Jamestown	572	6	1%	29	3	10%
Johnston	3,260	156	5%	621	137	22%
Lincoln	3,520	156	4%	324	137	42%
Little Compton	331	1	<1%	22	1	5%
Middletown	2,845	98	3%	482	80	17%
Narragansett	1,672	32	2%	171	21	12%
New Shoreham	130	5	4%	14	5	36%
Newport	2,920	540	18%	1,398	516	37%
North Kingstown	4,334	201	5%	494	163	33%
North Providence	3,378	217	6%	737	187	25%
North Smithfield	1,791	42	2%	148	20	14%
Pawtucket	9,491	1,416	15%	6,201	1,416	23%
Portsmouth	2,792	67	2%	158	35	22%
Providence	27,277	7,579	28%	21,692	7,579	35%
Scituate	1,711	25	1%	119	16	21%
Smithfield	2,625	76	3%	149	35	23%
South Kingstown	4,165	122	3%	567	109	22%
Tiverton	2,154	85	4%	355	46	13%
Warwick	12,084	645	5%	2,158	491	23%
West Warwick	3,659	401	11%	1,260	330	26%
Westerly	3,591	190	5%	681	190	28%
Woonsocket	6,534	1,153	18%	3,584	1,153	32%
Core Cities	*53,519*	*12,177*	*23%*	*37,072*	*11,852*	*32%*
Remainder of State	*99,233*	*5,214*	*5%*	*15,353*	*3,491*	*23%*
Rhode Island	*152,752*	*17,391*	*11%*	*52,425*	*15,343*	*29%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, October 2001 and October 2002. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

Fall enrollment is the public school enrollment as of October 1, 2001. Average daily participation in breakfast is the number of students eating breakfast in school on average in the month of October 2002. Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the month of October 2001. Low-income average daily participation in breakfast is the number of students eligible for and enrolled in free or reduced price lunches, eating breakfast in school on average in the month of October 2002. Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.[7]

References for Indicator

[1] *The Consequences of Hunger and Food Insecurity for Children: Evidence from Recent Scientific Studies* (June 2002). Waltham, MA: Brandeis University, Center on Hunger and Poverty.

[2,3,5,6] *School Breakfast Scorecard 2002: FRAC's Annual Status Report on the School Breakfast Program* (2002). Washington, DC: Food Research and Action Center.

[4] *The Rhode Island Food Security Monitoring Project: Assessing the Prevalence of Hunger and Food Insecurity in Rhode Island Year 2000 Summary Report* (January 2001). The Rhode Island Department of Health, Division of Family Health.

[5] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1995.

[6] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 2002.

[7] *Evaluation of the Universal School Breakfast Program Pilot Project: Key Interim Report: Findings from the First Year of Implementation* (November 2002). Washington, DC: U.S. Department of Agriculture.

[8] The George Wiley Center, Cranston, RI, February, 2003.

To a Child Dancing in the Wind

Dance there upon the shore;
What need have you to care
For wind or water's roar?
And tumble out your hair
That the salt drops have wet;
Being young you have not known
The fool's triumph, nor yet
Love lost as soon as won,
Nor the best labourer dead
And all the sheaves to bind.
What need have you to dread
The monstrous crying of wind?

William Butler Yeats

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children below age 19 who are covered by any kind of public or private health insurance, including Medicaid during the previous calendar year.

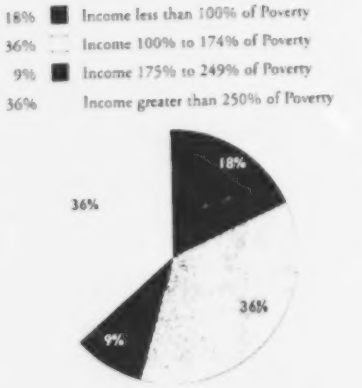
SIGNIFICANCE

Children's health insurance status is the major determinant in whether children have access to care. Children who lack insurance coverage are more likely to have poor health outcomes at birth and have fewer well-child visits.[1,2] Insured children are more likely than uninsured children to receive medical care for common conditions like asthma and ear infections – illnesses that if left untreated can have life-long consequences and lead to more serious health problems.[3]

When parents are insured and have access to health care, their children are also more likely to use health care.[4] Children's health insurance status is linked to parental access to employer-sponsored insurance. As the unemployment rate rises, the number of uninsured people grows due to the loss of employer-sponsored insurance. Over the past decade, the effect of decreased access to employer-sponsored insurance has been lessened by increased access to public insurance.[5]

RIte Care/RIte Share, Rhode Island's Medicaid managed care program, is available to inome - eligible children and families. Of the 117,507 RIte Care members enrolled as of December 31, 2002, nearly two-thirds (76,151) were children under age 19. There were 41,356 low-income parents enrolled in RIte Care as of December 31, 2002. Of these, 12,546 received RIte Care because they were enrolled in FIP (Family Independence Program).[6]

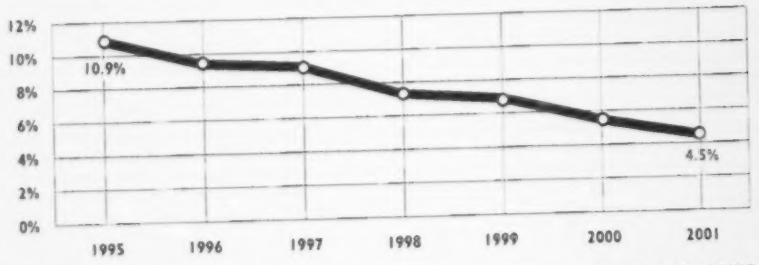
Children Under Age 19 without Health Insurance, by Poverty Level, Rhode Island, 2001



n = 11,000

Source: U.S. Bureau of Census, Current Population Survey, 2000-2002 average. Compiled by The Annie E. Casey Foundation. These data reflect only those who were uninsured through the entire year and do not include those who were insured for only part of the year.

Children without Health Insurance, Rhode Island, 1995 - 2001



Source: US Census Bureau, Current Population Survey, 1994-2002, 3 year averages, compiled by Rhode Island KIDS COUNT

◆ As of 2001, 4.5% of Rhode Island's children under age 19 were uninsured, the lowest rate of uninsured children in the country.[7] Nationally, 13% of children under 19 were uninsured.[8] The rate of uninsured children in Rhode Island has been reduced by more than half over the past six years.[9]

◆ As of 2001, there were 11,000 uninsured children in Rhode Island. Of these, an estimated 7,000 Rhode Island children were eligible for RIte Care but uninsured. Ninety-one percent of Rhode Island's uninsured children live in working families.[10]

RIte Care/RIte Share Program Updates

◆ During 2002, RIte Share expanded to include 1,061 adults and 1,844 children.[11] RIte Share, Rhode Island's health insurance premium assistance program, enables eligible families with access to employer-sponsored insurance to participate in their employer's insurance plan. RIte Share pays the employer's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan.[12]

◆ Eligibility guidelines for RIte Share are the same as for RIte Care, i.e. the employee must have a RIte Care-eligible family member in order to enroll in RIte Share. RIte Share provides the full range of RIte Care benefits to families by covering RIte Care services not included in the employer's health plan.[13]

Table 11.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 2002

CITY/TOWN	RIte Care FIP	RIte Care Non-FIP	SSI	Other	Total
Barrington	34	180	11	56	281
Bristol	195	501	29	41	766
Burrillville	133	458	40	139	770
Central Falls	1,809	2,330	235	26	4,400
Charlestown	62	218	9	27	316
Coventry	294	936	59	170	1,459
Cranston	1,107	2,582	204	262	4,155
Cumberland	204	672	49	131	1,056
East Greenwich	68	206	15	67	356
East Providence	842	1,851	144	153	2,990
Exeter	37	130	3	45	215
Foster	31	85	2	35	153
Glocester	52	227	14	73	366
Hopkinton	37	264	11	13	325
Jamestown	22	63	6	21	112
Johnston	376	932	66	60	1,434
Lincoln	160	508	31	75	774
Little Compton	15	41	3	4	63
Middletown	120	399	39	60	618
Narragansett	118	266	17	71	472
New Shoreham	1	18	1	0	20
Newport	1,023	1,019	105	72	2,219
North Kingstown	255	704	40	84	1,083
North Providence	448	930	60	110	1,548
North Smithfield	40	158	13	53	264
Pawtucket	3,460	4,933	476	211	9,080
Portsmouth	59	319	9	69	456
Providence	15,084	15,263	1,818	2,470	34,635
Richmond	44	143	15	45	247
Scituate	59	269	14	62	404
Smithfield	71	263	20	62	416
South Kingstown	243	559	49	103	954
Tiverton	123	382	29	31	565
Warren	183	339	24	42	588
Warwick	845	2,553	203	312	3,913
West Greenwich	27	126	4	33	190
West Warwick	637	1,334	96	100	2,167
Westerly	298	795	45	57	1,195
Woonsocket	2,302	2,577	372	228	5,479
Out of State	*137*	*32*	*0*	*0*	*169*
Unknown	*276*	*148*	*70*	*51*	*545*
Core Cities	*24,315*	*27,456*	*3,102*	*3,107*	*57,980*
Remainder of State	*6,603*	*18,077*	*1,278*	*2,566*	*28,524*
Rhode Island	*31,331*	*45,713*	*4,450*	*5,724*	*87,218*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 31, 2002. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The column labeled "RIte Care/FIP" is the number of children enrolled in RIte Care as of December 31, 2002 who also participate in the Family Independence Program. "RIte Care, Non-FIP" includes all other RIte Care participants under the age of 19 and pregnant women. "SSI" is children enrolled in fee-for-service Medicaid because they receive SSI. "Other" includes children in DCYF out-of-home placements (foster care) and non-SSI children with disabilities who are enrolled in fee-for-service Medicaid. "Other" also includes 1,981 children in DCYF out-of-home placements (foster care) who are enrolled in RIte Care under an initiative begun with DCYF in November 2000. The Providence numbers may include foster children who live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

References for Indicator

[1] Yu, S. M., et al. (2002). "Factors that Influence Receipt of Recommended Preventive Pediatric Health and Dental Care" in *Pediatrics* Vol. 110, No.6 Washington, DC: American Academy of Pediatrics.

[2] *Health Insurance is a Family Matter* (2002). Washington, DC: The National Academies Press.

[3] *Children's Health - Why Health Insurance Matters* (2002). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[4] *Medicaid Matters for America's Families* (2002). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[5] *The Number of Americans Without Health Insurance Rose in 2001 and Appears to be Continuing to Rise in 2002* (2002). Washington, DC: Center on Budget and Policy Priorities.

[6,11] Rhode Island Department of Human Services, MMIS Database, December 31, 2002.

[8,9] US Bureau of Census, Current Population Survey, 2000-2002 average. Compiled by The Annie E. Casey Foundation.

[7,8] U.S. Bureau of the Census, Current Population Survey, 1992-1996 average and 2000-2002 average. Compiled by Rhode Island KIDS COUNT.

[10,12] RIte Care/RIte Share Fact Sheet (August 2002) Cranston, RI: Rhode Island Department of Human Services.

Childhood Immunizations

DEFINITION

Childhood immunizations is the percentage of children ages 19 months - 35 months who have received the entire 4:3:1:3:3 Series of vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP). The Series includes 4 doses of Diphtheria, Tetanus and Pertussis (DTaP); 3 doses of Polio; 1 dose of Measles, Mumps, Rubella (MMR); 3 doses of Haemophilus influenzae type b (Hib); and 3 doses of Hepatitis B vaccines. The ACIP has also added pneumococcal disease and varicella (chickenpox) vaccines to its recommendations, but they are not included in the 4:3:1:3:3 Series.

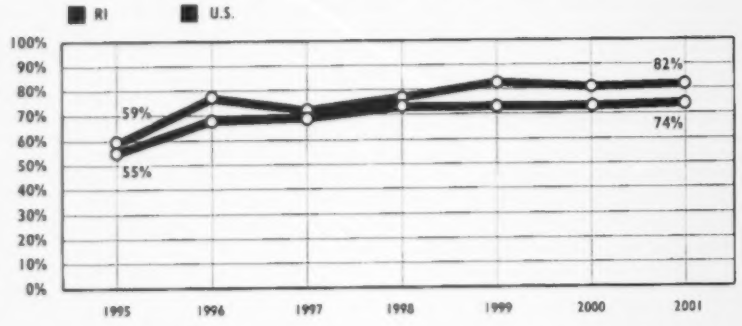
SIGNIFICANCE

Adequate immunization protects children against several diseases that killed or disabled children in past decades.[1] Vaccines interact with the immune system to produce antibodies which protect the body if exposed to the disease in the future.[2] Individual benefits of vaccination include protection from illness, improved quality of life and productivity, and prevention of death. Societal benefits include creation and maintenance of community immunity, prevention of disease outbreaks, and reduction of health-related costs.[3] Although many of the diseases children are vaccinated for are rare, it is important to continue to immunize them until the diseases are completely eradicated.[4]

Since coming into widespread use, immunizations have saved billions of lives around the world.[5] Vaccines are one of the most cost-effective tools in preventing disease.[6] In order to eliminate cost as a barrier to vaccination, the federal Vaccines for Children (VFC) program allows states to purchase vaccines at a discounted price. Providers then administer the vaccines at no cost to eligible children including those who are uninsured, underinsured, or Medicaid eligible. Rhode Island is one of a few states that purchases all vaccines for children and distributes them to providers[7,8]

Vaccine recommendations for the United States are created by the Advisory Committee on Immunization Practices, a group of health experts who advise the Centers for Disease Control and the U.S. Department of Health and Human Services.[9] In accordance with national recommendations, Rhode Island requires vaccination against the following diseases prior to entry into child care, Head Start or kindergarten: Diphtheria, Tetanus and Pertussis (DTaP); Hepatitis B; Haemophilus influenzae type b (Hib); Measles, Mumps, Rubella (MMR); Polio; and Varicella (chickenpox).[10]

Immunized Children, Ages 19 Months – 35 Months, United States and Rhode Island, 1995-2001

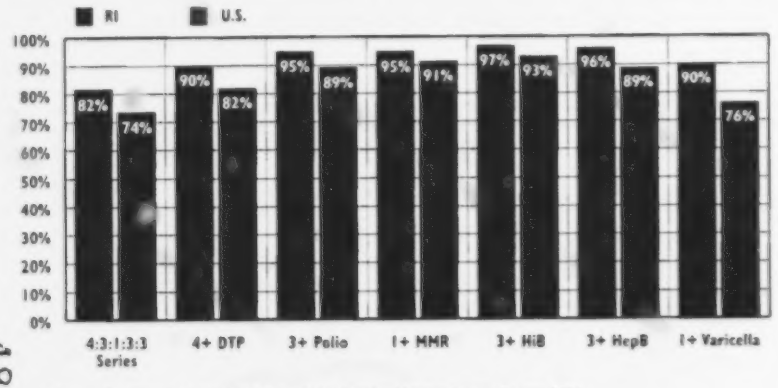


Source: Centers for Disease Control and Prevention, National Immunization Survey, 1995-2001.

◆ In 2001, 82% of Rhode Island children ages 19-35 months were fully immunized with the 4:3:1:3:3 Series, compared to 74% nationally. Immunization rates increased by 40% in Rhode Island between 1995 and 2001, compared to a 34% increase nationwide.[11]

◆ Despite the improvement of vaccination rates overall, racial and economic disparities persist. In the United States during 2001, 75% of White children were fully immunized compared to 67% of Black children. Children at or above the poverty level had a 75 % vaccination rate while children below the poverty level had a 68% vaccination rate.[12]

Estimated Vaccination Coverage Among Children Ages 19 Months - 35 Months, United States and Rhode Island, 2001



Source: Centers for Disease Control and Prevention, National Immunization Survey, 2001.

◆ Rhode Island ranked among the top ten states on vaccination rates for every childhood vaccine in 2001. Rhode Island had the best vaccination rates in the nation for 3+Hep B (hepatitis B), 1+Varicella (chickenpox) and the 4:3:1:3:3 Series.[13]

◆ The Rhode Island Immunization Program conducts an annual statewide school immunization survey to assess immunization levels of children attending licensed child care centers and Head Start programs, entering kindergarten, and 7th grade. The 2001-2002 Rhode Island School Immunization Survey included 45,060 children over the age of 19 months across 753 sites. Immunization rates for each of the vaccines included in the survey were above 90% for children in child care, Head Start and kindergarten.[14]

◆ Varicella (chickenpox) vaccine was added to the national ACIP recommendations in 1996. In 1999, Rhode Island included varicella vaccine in preschool and school entry requirements and expanded to 7th grade entry in 2000.[15] In 2001, Rhode Island ranked first in the nation for the percentage of 19-35 month olds vaccinated against varicella (90%). The national average for varicella vaccination was 76% in 2001.[16]

Adolescent Immunization

◆ Many adolescents are affected by diseases that are preventable with proper vaccination. Adolescents who have not been previously vaccinated against varicella (chicken pox) and hepatitis B or received a second dose of measles, mumps and rubella (MMR) need to be immunized and all adolescents require a booster dose for tetanus and diphtheria (Td).[17]

◆ In order to ensure that all teenagers are appropriately vaccinated before they leave school, the Rhode Island Department of Health's Immunization Program has partnered with the Rhode Island Childhood Immunization Action Coalition to create Vaccinate Before You Graduate (VBYG). The program informs parents and educates students on the importance of immunization and then holds vaccination clinics throughout the year at each participating school. The immunizations are funded through the state's Vaccine for Children Programs and are offered at no cost to students.[18]

◆ During the 2001-2002 school year, 31 schools participated in the program. Of the 1,090 students who returned consent forms, 94% were vaccinated and 75% completed the requested course of vaccinations. As of January 2003, 66 schools were enrolled in the program.[19]

References for Indicator

[1] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 7th ed. (2002). Waldorf, MD: Public Health Foundation.

[3] Atkinson, W.L. et al (February 2002). "General Recommendations on Immunization" in *MMWR*, Vol. 51, RR-2.

[4] *Why Immunize?* (2001). Bethesda, MD: Centers for Disease Control and Prevention, National Immunization Program.

[5] *The Effectiveness of Immunizations* (2003). Bethesda, MD: Centers for Disease Control and Prevention, National Vaccine Program Office.

[6] *Immunizations Appropriations Fact Sheet* (2002). Washington, DC: Association of State and Tribal Health Officers.

[7] *Vaccines for Children Program: Provider Information* (2002). Bethesda, MD: Centers for Disease Control and Prevention, National Immunization Program.

[8,9] *NPI Reference Guide on Vaccines and Vaccine Safety* (2002). Washington, DC: National Program for Immunization.

[10] *State Vaccine Requirements: Rhode Island* (2002). Washington, DC: National Network for Immunization Information.

[11,12,13,14] Centers for Disease Control and Prevention, National Immunization Survey, 2001.

[14] Rhode Island Department of Health, RI School Immunization Survey, 2001-2002.

[15] Rhode Island Department of Health, Varicella School Sentinel Surveillance, 2001-2002.

[17] *Recommended Childhood and Adolescent Immunization Schedule—United States, 2003* (2002). Bethesda, MD: Centers for Disease Control and Prevention, National Immunization Program.

[18,19] Rhode Island Department of Health, Division of Family Health, Vaccinate Before You Graduate Program, 2001-2002.

Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 21 who are enrolled in RIte Care or Medicaid fee-for-service who have received dental prevention or treatment services during state fiscal year 2000.

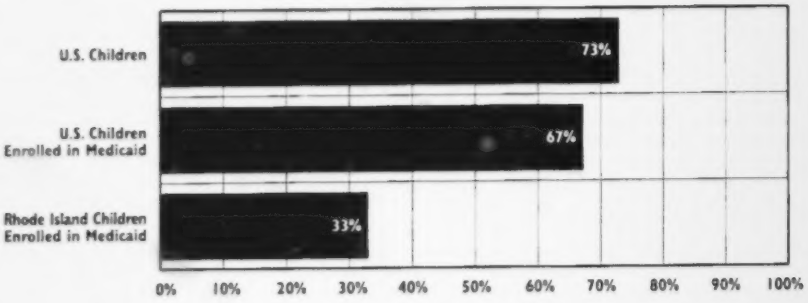
SIGNIFICANCE

Dental caries (tooth decay) is the most common disease among children 5 to 17 years old.[1] Preschool children with untreated dental caries are more likely to develop poor eating habits, to have difficulty socializing with peers, and to have speech problems. Children with poor dental health are at increased risk for future dental caries in their permanent teeth.[2] Chronic dental problems in school-age children and adolescents can lead to poor self-image, difficulty concentrating, absenteeism and reduced school performance.[3]

Children without dental insurance are three times as likely as privately-insured children to be unable to access dental care when needed.[4] In 1999 in Rhode Island, fewer than half (45%) of employers offered dental insurance as a benefit.[5] National estimates indicate that for every child without medical insurance there are 2.6 children without dental insurance.[6] Minority families, low-income families and families with low education levels are the most likely to be uninsured for dental care.[7]

For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[8] The federal Medicaid program mandates that states provide comprehensive dental services to eligible children up to age 21 including preventive dental care, dental treatment services, translation services, and transportation.[9] Barriers to obtaining oral health services for children enrolled in RIte Care or Medicaid fee-for-service include difficulty finding a provider who will accept Medical Assistance, inadequate financial resources to pay for dental care, and lack of parental education on the need for dental prevention and treatment services.[10] Obtaining services from dental specialists is especially difficult for children covered through public health insurance programs.[11] Children with disabilities or special health care needs may also have problems accessing providers that are equipped to address their special needs.[12]

Children with a Dental Visit in the Previous Year, United States and Rhode Island



Source: Centers for Disease Control and Prevention, Summary Health Statistics for U.S. Children: National Health Interview Survey, 1998, and Rhode Island Department of Human Services, Calendar Year 2000. Rhode Island data include RIte Care and Medicaid fee-for-service.

◆ In the United States, approximately 73% of all children and 67% of children enrolled in Medicaid or other public insurance have seen a dentist in the past year.[13] Among Rhode Island children under age 21 enrolled in public insurance programs, only one in three (33%) accessed dental prevention or treatment services during calendar year 2000.[14]

◆ Children in families with incomes below the poverty level and minority children have the greatest extent of untreated dental problems. Children eligible for Medicaid services experience twice the ratio of untreated dental disease as more affluent children.[15]

◆ The reluctance of many dentists to accept patients with Medicaid coverage compounds a general shortage of dentists nationwide, especially in urban areas. Low reimbursement rates that fail to cover the cost of services and administrative difficulties are two reasons cited by dentists for limiting or not serving Medicaid patients.[16] State efforts to attract more dentists to Medicaid by paying higher fees and streamlining administrative requirements have resulted in increased access to dental care services.[17]

Oral Health and Schools

◆ Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life. Children with chronic dental pain are unable to focus, are easily distracted and may have problems completing schoolwork. When children with acute dental problems are treated, their grades and school attendance improve.[18]

◆ School-based dental programs are an efficient way to reach children who do not regularly access dental care. In addition to providing students with preventative oral health services, they educate families on the importance of oral health and proper dental hygiene. Options for providing school-based dental services include on-site dental clinics that are linked to school health clinics, to dental treatment services in the community, and/or to mobile dental services.[19]

◆ School-based health programs have unique strengths that make them particularly capable of meeting the needs of children, especially low-income children who are at greatest risk for untreated dental problems. Health services based in schools allow students to seek care with minimal disruption to the school day and miss fewer classes. Parents are not required to take time off from work, find child care, or access transportation in order to obtain care for their children, all of which may be particularly difficult for single and low-income parents.[20]

◆ In the U.S., elementary school students with access to a school-based health center are more likely to have had a dental exam than students without access. Uninsured students have greater success in obtaining dental services at schools with health centers than at those without.[21,22]

References

[1,2,4,7,15] *Oral Health In America: A Report of the Surgeon General* (2000). Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

[2] *Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries* (June 1999). Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[3] *1999 Survey of Rhode Island Employers on Health Care Coverage* (2001). Providence, RI: Rhode Island Department of Health, Office of Health Statistics.

[4] *Factors Contributing to Low Use of Dental Services by Low-Income Populations* (2000). Washington, DC: United States General Accounting Office.

[5,6] *The Special State Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents*, Senator Elizabeth H. Roberts, Chair (November 2001). Providence, RI: Rhode Island State Senate.

[11] *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments* (1999). New York, NY: Milbank Memorial Fund.

[12] *Inequalities in Access: Oral Health Services for Children and Adolescent with Special Health Care Needs* (2000). Georgetown, MD: National Center for Education in Maternal and Child Health, Georgetown University.

[13] *Summary Health Statistics for U.S. Children: National Health Interview Survey, 1998* (2002). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics.

[14] Rhode Island Department of Human Services, January 2001.

[16,17] *The Disparity Cavity: Filling America's Oral Health Care Gap* (2000). Chicago, IL: Oral Health America and the W.K. Kellogg Foundation.

[18] *Oral Health and Learning* (2001). Georgetown, MD: National Center for Education in Maternal and Child Health, Georgetown University.

[19] *Addressing Oral Health Needs: A How To Guide* (2002). Boston, MA: Community Catalyst, Inc. and Health Care For All.

[20] Hurwitz, N. and Hurwitz, S. (August 2000). "The Case for School-Based Health Centers" in *American School Board Journal*, Vol. 189, No. 8.

[21] Hacker, K.A., et al (1998). "American's Views on Children's Health" in *Journal of the American Medical Association*, Vol. 280, No. 24.

[22] Kaplan, et al (1999). "A Comparison Study of an Elementary-Based Health Center: Effects on Health Care Access and Use" in *Archives of Pediatrics & Adolescent Medicine*, Vol. 153, No. 3.

Children's Mental Health

DEFINITION

Children's mental health is the number of children under age 18 using the mental health treatment system in Rhode Island.

SIGNIFICANCE

Mental health in childhood and adolescence is defined by the U.S. Surgeon General as the achievement of expected developmental, cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills.[1] One in five U.S. children ages 9 to 17 has a diagnosable mental or addictive disorder. One in ten suffers significant functional impairment as a result of their disorders.[2] Of all U.S. children with some mental or emotional problem or functional limitation it is estimated that only 19% see a mental health provider on a regular basis.[3] Children and youth with severe emotional disturbances who do not get early screening and prevention services are more likely to live in poverty and be dependent on the adult mental health system.[4]

Mental health problems affect children of all backgrounds. Children at risk for developing a mental disorder or experiencing problems in social-emotional development include those with prenatal damage from exposure to alcohol, illegal drugs, and tobacco; those born with low birth weight, difficult temperament, or an inherited predisposition to a mental disorder; children with external risk factors such as poverty, deprivation, abuse and neglect, unsatisfactory relationships, or exposure to traumatic events; and children whose parent has a mental health or substance abuse disorder.[5]

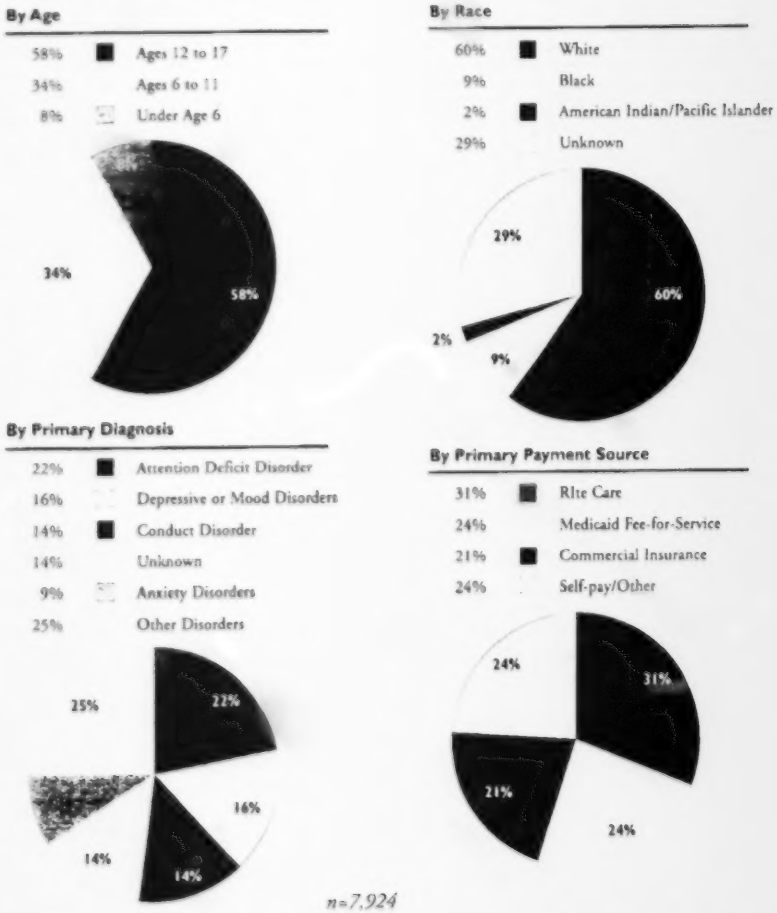
Both nationally and in Rhode Island, mental health systems tend to be crisis-driven with disproportionate spending on high-end hospital care and inadequate investment in prevention and a continuum of community services.[6,7,8] Children with mental health needs can be found in nearly every system serving children.

Primary health care settings and the schools are important sites for the identification of children with mental health needs and provide opportunities for early intervention.[9]

Nationally, the public school system is the sole provider of services for nearly half of all children receiving mental health services.[10] School systems are mandated to provide special education services to children and adolescents whose disabilities interfere with their education.[11] In the 2001-2002 school year, there were 2,857 Rhode Island children between the ages of 3 and 21 identified within the special education system as being disabled because of behavioral disorders.[12]

Rhode Island's Community Mental Health Centers

◆ During 2002, the eight community mental health centers in Rhode Island treated 7,924 children. As of December 31, 2002, there were 3,443 children receiving services through the community mental health centers.



Source: Rhode Island Department of Mental Health, Retardation and Hospital, data from eight community mental health centers, January-December 2002. Data for one month is missing for one mental health center.

Hospitals

◆ In calendar year 2000, 12,062 children were in enrolled in fee-for-service Medical Assistance by virtue of SSI eligibility (45%), subsidized/special needs adoptions (38%), Katie Beckett eligibility (8%) and DCYF out-of-home placement (8%).[13] The annual hospitalization rate for these children was 173 per 1,000. Children in DCYF out-of-home placement had a rate of 262 hospitalizations per 1,000. Nine out of ten hospitalizations of children in out-of-home placement were for mental disorders.[14]

◆ Bradley Hospital is Rhode Island's largest psychiatric center for children. In fiscal year 2002, 5,796 outpatient psychiatric visits were provided to children and there were 833 admissions of children to the hospital. An average of 40 families per day were served through Bradley's home-based program and an average of 156 students per day were served at Bradley's schools for children with mental illness and developmental disabilities. Bradley Hospital also serves children in partial hospital and residential treatment programs.[15]

◆ In fiscal year 2002, Rhode Island Hospital provided 12,484 child psychiatry outpatient visits and served 165 children and youth with medical/psychiatric conditions in its Hasbro Partial Hospital Program.[16]

◆ Butler Hospital provides a wide range of psychiatric services for children and adolescents. In 2002, Butler Hospital provided services to 876 children and youth age 18 and under, as compared with 1,179 in the previous year and 2,338 in 2000. Of the 876 children served in 2002, 724 were admitted to the hospital and the remaining 152 were in partial hospital or outpatient programs.[17]

Supporting Families of Children with Mental Illness

◆ The family caregivers of children with mental health issues are likely to feel isolated, pushed to the breaking point, and unsupported by friends, families, or the health and education systems.[18,19]

◆ In a 1998 Rhode Island survey of family caregivers of mentally ill children:

- 83% reported feeling overwhelmed.
- 74% were unable to find child care appropriate to their child's needs.
- 81% lacked information on their child's primary condition.
- 99% reported a need for parent education classes.
- 99% reported a need for respite care.[20]

◆ A growing body of research and practice indicates that a comprehensive mental health system for children needs to include: multiple and diverse support systems for families, skill-building for parents, teachers and other caregivers, and prevention and treatment provided in natural settings, such as homes, schools, child care centers and community organizations.[21,22,23,24]

References

[1,2,3,4,20] *Mental Health: A Report of the Surgeon General* (1999). Washington, DC: Office of the Surgeon General, U.S. Department of Health and Human Services.

[3] *Mental Health, United States, 2000* (2000). Washington, DC: Office of the Surgeon General, U.S. Department of Health and Human Services.

[4,5] Allen, M. (September 2002). *The Well-Being of Our Nation: An Inter-Generational Vision of Effective Mental Health Services and Supports*. Washington, DC: National Council on Disability.

[7] *Toward an Organized System of Care for Rhode Island's Children, Youth and Families* (October 21, 2002). The Report of the Rhode Island System of Care Task Force.

[8,11] *A Review of the Department of Children, Youth and Families* (January 2001). Providence, RI: Rhode Island Public Expenditure Council, Commissioned by Rhode Island Children's Policy Coalition.

[9,21] Knitzer, J. (January 2002). *Promoting the Emotional Well-Being of Children and Families: Building Services and Systems to Support the Healthy Emotional Development of Young Children*. New York, NY: National Center for Children in Poverty.

[10] *School-Based Health Centers in Rhode Island* (2000). Providence, RI: Rhode Island Department of Health.

[12] Rhode Island Department of Elementary and Secondary Education, School Year 2001-2002.

[13,14] *Rhode Island Medicaid Program, Fiscal Year 2002, Annual Report* (2002). Cranston, RI: Department of Human Services.

[15] Bradley Hospital, fiscal year 2002.

[16] Rhode Island Hospital, 2001 and 2002.

[17] Butler Hospital, 2000, 2001, 2002.

[18] *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers* (1999). The National Alliance for the Mentally Ill.

[19,20] Griffin, J. (1998). *Health Care Needs of Children with Disability on Medicaid: Results of Caregiver Survey*. Providence, RI: MCH Evaluation, Inc.

[22] Wishman, A. et al (March 2002). *Funding Early Childhood Mental Health Services and Supports*. Washington, DC: Georgetown University Child Development Center.

Children with Special Needs

DEFINITION

Children with special needs are those who have a chronic disease or disability that requires educational services, health care, and/or related services of a type or amount beyond that required by children generally. Special needs can be physical, developmental, behavioral, and/or emotional. This indicator measures the number of children enrolled in Early Intervention, Special Education, and Supplemental Security Income (SSI) in 2002.

SIGNIFICANCE

As many as 18% of children nationwide have a chronic physical, developmental, behavioral or emotional condition that requires health care and related services.[1] Some chronic and disabling conditions among children include mental retardation, attention deficit disorder, asthma, autism, hearing impairment, communication disorders, seizure disorders, and congenital diseases.[2,3]

Children with special needs are a heterogeneous group, varying by the type and severity of the chronic disease or disability. Needs will vary based on the age of the child, as well as by the many differences in the population at large, such as family income, race, ethnicity, primary language, and parents' educational level.[4] Children with chronic or disabling conditions are likely to have functional limitations or impairments in physical, social, emotional or behavioral functioning in comparison with their peers of the same age.[5] Youth with special needs are much less likely than their non-disabled peers to finish high school, go on to postsecondary education, find employment, and live independently.[6]

There are some issues of common concern to families of children with chronic or disabling conditions. Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, family support, child care, recreation, and career preparation. For many parents, having a child with special needs has a significant impact on their finances, their jobs, and their family life.[7,8]

Children with special needs require access to services that are appropriate to their individual health, education, and social-emotional needs in order to reach their full potential and minimize the likelihood of life-long dependence.[9,10] Some children with disabilities may require costly therapeutic and health care services, wheelchairs, assistive technology, or home modifications which may result in serious financial burdens on families.[11]

Medical Assistance Coverage for Children with Special Health Care Needs

◆ Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the federal Supplemental Security Income (SSI) program.[12] As of December 31, 2002, there were 4,450 Rhode Island children receiving Medical Assistance benefits because of their enrollment in SSI.[13]

◆ One national study indicates that many children with special health care needs do not qualify for SSI and that 85% of the children with special needs enrolled in Medicaid did not enter the Medicaid system by reason of SSI eligibility.[14]

◆ In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children under the age of 18 who have serious disabling conditions, in order to enable them to be cared for at home instead of in an institution. As of December 31, 2002, there were 1,207 Rhode Island children enrolled in Medical Assistance because of eligibility through the Katie Beckett provision.[15] Another 135 children were receiving Medical Assistance because of participation in long-term care, waiver and other specific circumstances.[16]

Children in the Child Welfare System

◆ According to the National Survey of American Families, 27% of children in the child welfare system across the U.S. show high levels of behavioral and emotional problems and 28% have a physical, learning, or mental health condition that limits their activities.[17]

◆ More than half of young children in foster care experience serious physical problems and over half experience developmental delays. This is four to five times the rate of developmental delay found among children in the general population.[18]

◆ Children who are adopted through the Department of Children, Youth and Families and have special needs may qualify for adoption subsidies, including Medical Assistance. As of December 31, 2002, 2,236 children were receiving Medical Assistance because of special needs adoptions. In addition, 2,161 children were enrolled in Medical Assistance due to their foster care status.[19]

Children Enrolled in Early Intervention

◆ States are required to provide appropriate Early Intervention services to all children from birth to age 3 who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.[20] One important focus of the program is on enhancing the capacity of families to meet the needs of their children by supporting the needs of the entire family.[21]

◆ In 2002, the seven Early Intervention programs in Rhode Island served 2,504 children ages birth to three.

◆ In 2002, 63% of children served had significant developmental delays, i.e. physical, cognitive, behavioral, and/or emotional delays of unknown medical origin. One in five (21%) had a single established condition affecting development, such as Down Syndrome or cerebral palsy.

◆ Seven percent of children served had multiple established conditions, i.e. evidence of developmental delay in combination with multiple prenatal or early life biological events that put the child at risk of further developmental delays. Risk criteria include teen parents, impoverished home environment, poor nutrition, and others.

Source: Rhode Island Department of Health, December 31, 2002

Children Enrolled in Special Education

◆ Local school systems are responsible for identifying and evaluating students ages 3 to 21 whom they have reason to believe are students with disabilities and therefore might require special education and related services.

◆ In Rhode Island during the 2001-2002 school year, there were 33,058 public school children enrolled in Special Education, 22% of the public school student population. Almost half of all children in special education n Rhode Island have a learning disability.

◆ Early Intervention programs for children birth to age 3 are required to provide transition services for children who may be eligible for Special Education at age 3. In 2002, 420 children who reached age 3 were referred from Early Intervention to Special Education. During the 2001-2002 school year, there were 2,425 children ages 3 to 5 receiving Special Education services in Rhode Island public schools (who were not yet in kindergarten).

Source: The Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2002.

References

[1] *Access to a Medical Home* (July 2001). Rockville, MD: Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[2,3] Terman, D.L., Larner, M.B., Stevenson, C.S., Behrman, R.E. "Special Education for Students with Disabilities" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[2,3,4] Wells, N. et al (2000). *What Do Families Say About Health Care for Children with Special Health Care Needs? Your Voice Counts!!* Boston, MA: Family Voices at the Federation for Children with Special Health Care Needs.

[5] Msall, M. et al *Functional Disability and School Activity Limitations in 41,300 School-Age Children. Relationship to Medical Impairments* [Manuscript]. (January 2002). Providence, Rhode Island: Brown University Department of Pediatric Research.

[6] *Healthy and Ready to Work* (July 2001). Rockville, MD: Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[7] Griffin, J. (June 1998). *Health Care Needs of Children with Disabilities on Medicaid: Results of a Caregivers Survey*. Cranston, RI: RI Department of Human Services, Center for Child and Family Health and RI Department of Health, Disability and Health Program.

[8] *The Well-Being of Our Nation. An Inter-Generational Vision of Effective Mental Health Services and Supports* (September 2002). Washington, DC: National Council on Disability.

[9] *Social Security: Supplemental Security Income* (July 1998, Informational Brochure). Washington, DC: Social Security Administration.

[10,11,12] Rhode Island Department of Human Services, Center for Child and Family Health (December 31, 2002).

[13] Allen, S.M. and A.L. Croke (October 2000). *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities*. Princeton, NJ: Center for Health Care Strategies, Inc.

[14] Kortenkamp, K. and J. Ehrle (February 2002). *The Well-Being of Children Involved with the Child Welfare System: A National Overview*. Washington, DC: The Urban Institute.

[15] Dicker, S. et al (2001). *Improving the Odds for the Healthy Development of Children in Foster Care*. New York, NY: National Center for Children in Poverty.

[16] Shackelford, J. (June 2002). "State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities under IDEA" in *NECTAC Notes*. Issue No. 11. Chapel Hill, NC: National Early Childhood Technical Assistance Center.

[17] *National Early Childhood Longitudinal Study: Families' First Experiences with Early Intervention* (NEILS Data Report No. 2) (January 2003). Chapel Hill, NC: Frank Porter Graham Child Development Institute.

Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women, infants, and children under five years of age with household incomes below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible. Participants must have a specified nutritional risk, such as anemia, history of poor pregnancy outcomes or inadequate dietary patterns.[2,3]

WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children.[4] Rhode Island received $13.9 million dollars in federal funding during fiscal year 2002 and served 23,969 people.[5,6]

WIC participants purchase a monthly food package – an individually prescribed combination of targeted foods to improve the nutritional quality of their diets – at local retailers with checks or coupons.[7] WIC participants also receive nutrition education and health care referrals through the program.[8] WIC promotes breastfeeding as the optimal method of infant feeding and program eligibility for breastfeeding mothers is extended for up to one year.[9] Between 1993 and 2002, the percentage of WIC infants who were breastfed more than doubled, increasing from 6.4% to 14.6%.[10]

WIC participation improves birth outcomes, increases the nutrient intake of preschoolers, increases breastfeeding rates and immunization coverage, improves cognitive development and increases the likelihood of having a regular medical care provider.[11]

Overweight Children and Childhood Obesity

◆ WIC was first established in 1972 to combat malnutrition and hunger in low-income Americans. Since that time, overweight and obesity have become a serious heath issue in the United States. An estimated 1 in 10 children in the WIC program is overweight, an increase of 20% since 1983.[12]

◆ The increase of overweight and obesity among WIC participants may be related to the overall increase in the general population and the prevalence of overweight among low-income groups that are served by the program. Because the goal of the WIC program is to improve nutrition and healthy eating, overweight is one of the nutritional risk criteria used to determine eligibility.[13]

◆ Participation in WIC provides a unique opportunity for overweight children and their families to improve their health. WIC foods are more nutritious than typical foods in poor children's diets, its educational counseling promotes healthy food choices and age-appropriate physical activity and its health referral component increases access to medical intervention for overweight.[14]

Table 12. **Women, Infants and Children Receiving WIC, Rhode Island, December 2002**

CITY/TOWN	ESTIMATED* NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	29	14%
Bristol	403	180	45%
Burrillville	427	226	53%
Central Falls	1,642	1,517	92%
Charlestown	105	85	81%
Coventry	592	282	48%
Cranston	1,753	871	50%
Cumberland	554	216	39%
East Greenwich	241	53	22%
East Providence	1,205	708	59%
Exeter	13	36	100%*
Foster	10	47	100%*
Glocester	293	28	10%
Hopkinton	33	82	100%*
Jamestown	96	13	14%
Johnston	598	294	49%
Lincoln	360	144	40%
Little Compton	63	9	14%
Middletown	694	248	36%
Narragansett	71	90	100%*
New Shoreham	39	1	3%
Newport	1,332	606	45%
North Kingstown	370	174	47%
North Providence	262	331	100%*
North Smithfield	59	48	81%
Pawtucket	3,198	2,772	87%
Portsmouth	249	84	34%
Providence	11,280	8,982	80%
Richmond	24	55	100%*
Scituate	75	60	80%
Smithfield	174	67	39%
South Kingstown	402	193	48%
Tiverton	260	89	34%
Warren	156	119	76%
Warwick	1,613	872	54%
West Greenwich	38	17	45%
West Warwick	777	664	85%
Westerly	648	307	47%
Woonsocket	2,566	1,561	61%
Unknown Residence	*NA*	*38*	*NA*
Core Cities	*20,795*	*16,102*	*77%*
Remainder of State	*12,091*	*6,058*	*50%*
Rhode Island	*32,886*	*22,198*	*67%*

**Estimated number eligible is based on the 1990 Census and does not reflect recent increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, Fiscal Year 2002.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the number of pregnant and post-partum women, infants and children under age 5 who live in families with an income less than 185% of poverty according to the 1990 Census of Population as estimated by the United States Department of Agriculture. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of women and children who became income eligible after 1990.

References for Indicator

[1] American Academy of Pediatrics (November 2001). "WIC Program" in *Pediatrics*, Vol. 108, No. 5.

[2,4] *Federal Food Programs: Special Supplemental Nutrition Program for Women, Infants, and Children* (2002). Washington, DC: Food Research and Action Center.

[3] *Frequently Asked Questions* (Factsheet) (2002). Washington, DC: United States Department of Agriculture, Food and Nutrition Service.

[5] *Summary of FY2002 Food and NSA Grant Level* (2002). Washington, DC: United States Department of Agriculture, Food and Nutrition Service.

[6,7] Rhode Island Department of Health, Division of Family Health, WIC Program, Fiscal Year 2002 and 1993.

[8] *About WIC* (2002). Washington, DC: United States Department of Agriculture, Food and Nutrition Service.

[9] *WIC at a Glance* (Fact Sheet) (2002). Washington, DC: United States Department of Agriculture, Food and Nutrition Service.

[10] *How WIC Helps* (August 2001). Washington, DC: United States Department of Agriculture, Food and Nutrition Service.

[11,12,13] Oliveira, V. et al (2002). The WIC Program: *Background, Trends and Issues*. Washington, DC: United States Department of Agriculture, Economic Research Service.

Breastfeeding

DEFINITION

Breastfeeding is the percentage of newborn infants who are exclusively breastfed at the time of hospital discharge.

SIGNIFICANCE

The American Academy of Pediatrics (AAP) identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as of primary imprtance in achieving optimal infant and child health, growth and development. The AAP recommends exclusive breastfeeding for approximately six months after birth and, in conjunction with appropriate solid foods, for at least 12 months after birth, and thereafter as long as mutually desired.[1] *Healthy People 2010*, the nation's health agenda, has established target breastfeeding rates of 75% at birth, 50% at six months and 25% at one year.[2] The 1998 *Healthy People 2010* baseline data shows that United States breastfeeding rates were 64% at birth, 29% at 6 months and 16% at one year.[3]

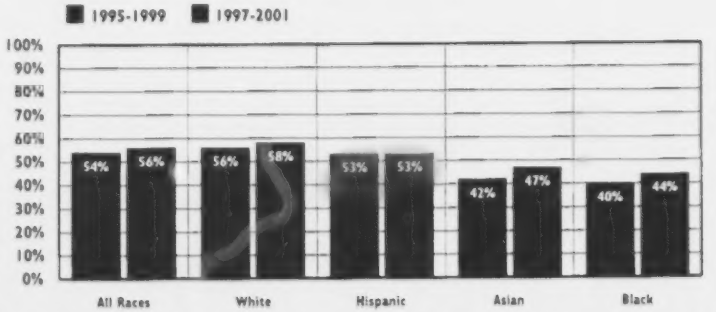
Breastfeeding provides optimal nutrition for the newborn and decreases the incidence of diarrhea, lower respiratory infections and ear infections. Breastfeeding has been linked to decreases in sudden infant death syndrome, diabetes, allergies, asthma, lymphoma and other illnesses; improved cognitive development and school performance in children; a reduced incidence of child abuse; and improved maternal health, including reduced rates of breast and ovarian cancer.[4,5,6]

Breastfeeding provides significant social and economic benefits including reduced cost to the family, reduced health care costs and reduced employee absenteeism.[7]

Nationally, the highest rates of breastfeeding, as measured by initiation in the hospital, occur among women who are White, over age 35, and college-educated. The lowest rates occur among women who are Black, less than 20 years old, have less than a 12th grade education, and participate in WIC or Medicaid.[8,9]

Breastfeeding can be effectively promoted by health professionals through culturally-appropriate prenatal and postnatal education of the mother, physician support, hospital policies that promote early and exclusive breastfeeding and provide ongoing lactation consultation, timely postpartum follow-up care, home health visits and links to lactation support networks and resources.[10]

Breastfeeding Rates by Race and Ethnicity, Rhode Island, 1995-2001



Source: Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program, 1995-2001.

◆ During the late 1990s, most racial and ethnic groups in Rhode Island made slow, but positive progress in breastfeeding rates. The breastfeeding rates for Black and Asian infants remain significantly lower than the rates for other racial and ethnic groups.[11]

◆ Race is a strong predictor of breastfeeding even after controlling for socioeconomic background. Black women in the United States and in Rhode Island have the lowest breastfeeding rates of any racial and ethnic group.[12]

◆ The most significant obstacle to continuing to breastfeed is a mother's need to return to work.[13] Black women are more likely than women of other races to return to work early (at eight weeks after birth) and to be engaged in jobs which make continued success in breastfeeding more difficult.[14]

◆ *Healthy People 2010* recommends several strategies for increasing breastfeeding rates among those at highest risk, including increased education for health care providers and new parents, additional support of breastfeeding from employers and the community, and greater media portrayal of breastfeeding as the normal method of infant feeding.[15]

Table 13.

Breastfeeding Rates, Rhode Island, 1997-2001

CITY/TOWN	NUMBER OF BIRTHS	BREASTFEEDING	PERCENT BREASTFEEDING
Barrington	791	642	81%
Bristol	1,018	606	60%
Burrillville	750	413	55%
Central Falls	1,726	869	50%
Charlestown	489	336	69%
Coventry	1,870	1,069	57%
Cranston	3,760	1,975	53%
Cumberland	1,615	1,023	63%
East Greenwich	766	562	73%
East Providence	2,435	1,287	53%
Exeter	309	201	65%
Foster	218	151	69%
Glocester	360	219	61%
Hopkinton	725	467	64%
Jamestown	191	157	82%
Johnston	1,442	693	48%
Lincoln	877	561	64%
Little Compton	106	85	80%
Middletown	1,042	766	74%
Narragansett	584	398	68%
New Shoreham	50	39	78%
Newport	1,680	1,099	65%
North Kingstown	1,575	1,163	74%
North Providence	2,148	1,072	50%
North Smithfield	519	326	63%
Pawtucket	4,849	2,487	51%
Portsmouth	862	652	76%
Providence	13,343	6,537	49%
Richmond	171	110	64%
Scituate	600	415	69%
Smithfield	743	490	66%
South Kingstown	1,406	1,022	73%
Tiverton	337	227	67%
Warren	543	313	58%
Warwick	4,214	2,298	55%
West Greenwich	292	206	71%
West Warwick	1,986	940	47%
Westerly	1,174	712	61%
Woonsocket	2,730	1,157	42%
Unknown	*343*	*50*	*N/A*
Core Cities	*26,314*	*13,089*	*50%*
Remainder of State	*34,325*	*20,706*	*60%*
Rhode Island	*60,639*	*33,795*	*56%*

Sources of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program Database, 1997-2001. Breastfeeding is defined as intended feeding method at hospital discharge. Births to Rhode Island women that occurred outside Rhode Island are not included.

References for Indicator

[1,6,7] American Academy of Pediatrics (December 1997). "Breastfeeding and the Use of Human Milk – Policy Statement" in *Pediatrics*, Vol. 100, No.6.

[2,3,5] *Healthy People 2010, Conference Edition, Vol. 2* (2000). Washington, DC: U.S. Department of Health and Human Services.

[4,8,9,10] *HHS Blueprint for Action on Breastfeeding* (2000). Washington, DC: U.S. Department of Health and Human Services, Office on Women's Health.

[5] Wright, N. (Spring/Summer 2000). "Breastfeeding and Early Childhood Development: Strategies for Proposition 10 Implementation" in *Breastfeeding: Best for Baby and Mother*, Vol. 2, No. 1.

[8] *Child Health USA 2002* (2002). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[9] Beck, L. et al (2002). "Prevalence of Selected Maternal Behaviors and Experiences, Pregnancy Risk Assessment Monitoring System (PRAMS), 1999" in *MMWR Weekly*, Vol. 51 No. SS02.

[11] Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program, 1995-2001.

[12] Forste, R. et al (August 2001). "The Decision to Breastfeed in the United States: Does Race Matter?" in *Pediatrics*, Vol. 108, No. 2.

[13] *Breastfeeding Position Paper* (2002). Leawood, KS: American Academy of Family Physicians.

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Early prenatal care is important to identify and treat health problems and influence health behaviors that can compromise fetal development, infant health and maternal health. Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn or who die within the first year of life.[1]

Prenatal care offers the opportunity to screen for and treat conditions that increase the risk for poor birth outcomes. Effective prenatal care also screens for and intervenes with a range of conditions including maternal depression, smoking, substance use, domestic violence, nutritional deficiencies, and unmet needs for food and shelter.[2] Women who receive adequate prenatal care are more likely to obtain preventive health care for their children, such as scheduling well-baby visits, immunizations, and regular health checkups.[3]

Early prenatal care is especially important for women who face multiple risks for poor birth outcomes, including poverty and low maternal education. Several studies indicate that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to social services, and home visits.[4]

Late or No Prenatal Care

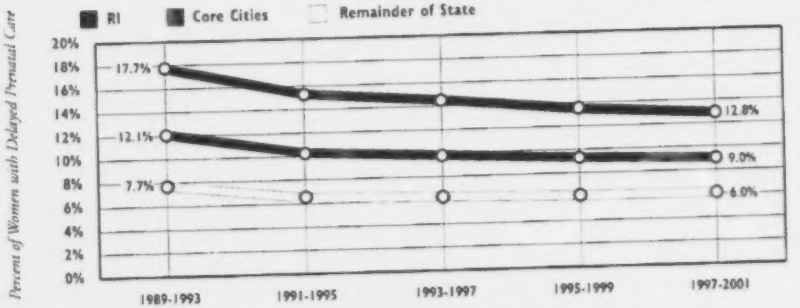
	1990	2000
RI	2.0%	1.3%
US	6.1%	3.9%
State Rank		*1st*

1st is best; 50th is worst

Late prenatal care is defined as beginning prenatal care in the third trimester.

Source: *The Right Start for America's Newborns, A Decade of City and State Trends: 1990-2000* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Delayed Prenatal Care, Rhode Island, Core Cities and the Remainder of the State, 1989-2001



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database. 1989-2001. Data for 1999-2001 are provisional. Delayed prenatal care is defined as beginning prenatal care later than the first trimester.

◆ During the 1990s, the rate of delayed prenatal care decreased across Rhode Island. However, women in the core cities remain twice as likely to receive delayed prenatal care as compared to women in the remainder of the state.[5]

◆ During 1997-2001, the women in the following communities were the least likely to receive prenatal care beginning in the first trimester of pregnancy: Central Falls (18.8%), Woonsocket (16.0%), Westerly (15.9%), Pawtucket (13.3%), Providence (12.0%), and Newport (11.4%).[6]

Smoking During Pregnancy

◆ Smoking during pregnancy increases the risk of pregnancy complications, low birthweight, stillbirth and sudden infant death syndrome (SIDS).[7] Pregnancy provides a unique opportunity to help women quit smoking. Studies have shown that providing brief medical counseling and pregnancy-tailored self-help materials during prenatal visits significantly increases quit rates.[8]

◆ In 1999, 14% of pregnant women in Rhode Island smoked cigarettes, compared to 13% nationally.[9] The percentage of Rhode Island women enrolled in RIte Care or Medicaid who smoked during pregnancy decreased significantly from 32% in 1993 to 24% in 2000.[10]

Table 14.

Delayed Prenatal Care, Rhode Island, 1997-2001

City/Town	# Births	# Delayed Care	% Delayed Care
Barrington	820	19	2.3%
Bristol	1,067	79	7.4%
Burrillville	781	53	6.8%
Central Falls	1,781	335	18.8%
Charlestown	446	39	NA
Coventry	1,924	102	5.3%
Cranston	4,171	242	5.8%
Cumberland	1,701	100	5.9%
East Greenwich	588	22	3.7%
East Providence	2,499	194	7.8%
Exeter	341	16	NA
Foster	197	11	NA
Glocester	464	28	NA
Hopkinton	488	53	NA
Jamestown	205	4	NA
Johnston	1,492	86	5.8%
Lincoln	990	57	5.8%
Little Compton	156	14	NA
Middletown	1,083	57	5.3%
Narragansett	667	21	3.1%
New Shoreham	57	9	NA
Newport	1,645	188	11.4%
North Kingstown	1,500	59	3.9%
North Providence	1,576	94	6.0%
North Smithfield	515	24	4.7%
Pawtucket	5,030	669	13.3%
Portsmouth	917	41	4.5%
Providence	13,589	1,631	12.0%
Richmond	472	30	NA
Scituate	504	27	5.4%
Smithfield	805	39	4.8%
South Kingstown	1,298	52	4.0%
Tiverton	649	58	8.9%
Warren	582	49	8.4%
Warwick	4,427	204	4.6%
West Greenwich	297	11	NA
West Warwick	2,024	171	8.4%
Westerly	1,373	218	15.9%
Woonsocket	2,980	478	16.0%
Unknown	9	0	NA
Core Cities	*27,049*	*3,472*	*12.8%*
Remainder of State	*35,061*	*2,112*	*6.0%*
Rhode Island	*62,110*	*5,584*	*9.0%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1997-2001.

References for Indicator

[1] *Trends in the Well-Being of America's Children and Youth 2001* (2002). Washington, DC: U.S. Department of Health and Human Services.

[2] American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health (June 2001). "The Prenatal Visit" in *Pediatrics* Vol. 107, No. 6.

[3] *The Right Start State Trends: Conditions of Babies and Their Families Across the Nation (1990-1998)* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[4] *Opportunities to Use Medicaid in Support of Maternal and Child Health Services* (2000). Rockville, MD: U.S. Department of Health and Human Resources, Health Resources & Services Administration.

[5A] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1989-1993 and 1997-2001.

[7] *Women and Smoking: A Report of the Surgeon General* (2001). Baltimore, MD: Centers for Disease Control and Prevention.

[8] Orleans, C. et al (2000). "Helping Pregnant Smokers Quit: Meeting the Challenge" in *The Next Decade in Tobacco Control*, Vol. 9, No. 3.

[9] *State Prenatal Smoking Databook 1999* (2002). Baltimore, MD: Centers for Disease Control and Prevention.

[10] J. Griffin (2002). *The Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborns, 2000 Update*. Cranston, RI: Rhode Island Department of Human Services, Center for Child and Family Health.

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

A baby's birthweight is a key indicator of newborn health and is directly related to infant survival and healthy development. Infants born weighing less than 5.5 pounds are at greater risk for physical and developmental problems than infants of normal weight.[1,2] Babies are born with low birthweight for two reasons: some are born prematurely and others are small for their gestational age.[3] Increased risk of low birthweight is strongly associated with poverty, maternal smoking and low levels of educational attainment.[4]

Low birthweight babies are at higher risk of death or long-term illness and disability than infants of normal birthweight.[5] They are 24 times more likely than babies of normal weight to die within the first year of life.[6] Children ages 6 to 15 years old who were born low birthweight are 50% more likely than children of normal birthweight to be enrolled in a special education program.[7]

At almost all educational levels, socioeconomic levels, and age categories, Black mothers are at greater risk for having a preterm delivery and a low birthweight infant.[8,9] These disparities are not entirely explained by differences in income or health behaviors.[10] In Rhode Island between 1997 and 2001, the incidence of low birthweight in Black infants was nearly double the rate in White infants and was higher than all other racial/ethnic groups.[11]

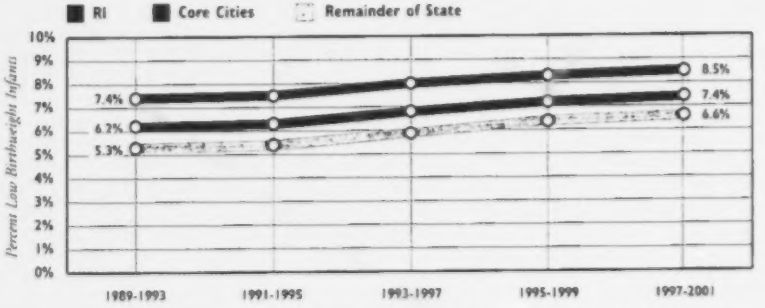
Low Birthweight Infants

	1990	2000
RI	6.2%	7.2%
US	7.0%	7.6%
State Rank		*21st*

1st is best; 50th is worst

Source: *The Right Start for America's Newborns: A Decade of City and State Trends (1990-2000)* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Low Birthweight Infants, Rhode Island, Core Cities and the Remainder of the State, 1989-2001



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1989-1993, 1991-1995, 1993-1997, 1995-1999 and 1997-2001. Data for 1999-2001 are provisional.

◆ Over the past decade, the percentage of infants born low birthweight has increased in Rhode Island, the core cities and the remainder of the state. This increase has occurred across all racial and ethnic groups.[12]

◆ One reason for the increase in low birthweight infants is the growing numbers of twin, triplet and higher-order multiple births. Twins and other multiple births are more likely to be low birthweight than single births.[13] From 1997 to 2001, 6% of single births were born low birthweight, compared to 52% of twin births and 96% of triplets and higher-order multiple births in Rhode Island.[14]

Table 15. **Low Birthweight Infants, Rhode Island, 1997-2001**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	820	38	4.6%
Bristol	1,067	72	6.7%
Burrillville	781	59	7.6%
Central Falls	1,781	150	8.4%
Charlestown	446	26	NA
Coventry	1,924	122	6.3%
Cranston	4,171	288	6.9%
Cumberland	1,701	124	7.3%
East Greenwich	588	32	5.4%
East Providence	2,499	161	6.4%
Exeter	341	15	NA
Foster	197	11	NA
Glocester	464	25	NA
Hopkinton	488	46	NA
Jamestown	205	11	NA
Johnston	1,492	118	7.9%
Lincoln	990	63	6.4%
Little Compton	156	12	NA
Middletown	1,083	46	4.2%
Narragansett	667	48	7.2%
New Shoreham	57	2	NA
Newport	1,645	100	6.1%
North Kingstown	1,500	76	5.1%
North Providence	1,576	129	8.2%
North Smithfield	515	41	8.0%
Pawtucket	5,030	393	7.8%
Portsmouth	917	57	6.2%
Providence	13,589	1,235	9.1%
Richmond	472	22	NA
Scituate	504	32	6.3%
Smithfield	805	48	6.0%
South Kingstown	1,298	71	5.5%
Tiverton	649	29	4.5%
Warren	582	49	8.4%
Warwick	4,427	342	7.7%
West Greenwich	297	10	NA
West Warwick	2,024	152	7.5%
Westerly	1373	79	5.8%
Woonsocket	2,980	240	8.1%
Unknown	*9*	*0*	*NA*
Core Cities 2000	*27,049*	*2,270*	*8.4%*
Remainder of State	*35,061*	*2,304*	*6.6%*
Rhode Island	*62,110*	*4,574*	*7.4%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Core Cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1997-2001.

References for Indicator

[1,4] *KIDS COUNT Data Book: State Profiles of Child Well-Being* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[2] *Maternal, Infant and Child Health in the United States (2001)*. Washington, DC: March of Dimes

[3,14,15] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[5] *Child Health USA 2002* (2002). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[7] Lewit, E., et al. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[8,9] Shore, R. (2002). *KIDS COUNT Indicator Brief: Preventing Low Birthweight (Draft)*. Baltimore, MD: The Annie E. Casey Foundation.

[11,12,13] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality and access to medical care, socioeconomic conditions, and public health practices.[1] Communities with multiple problems, such as poverty, unemployment, and illiteracy, tend to have higher infant mortality rates than more advantaged communities.[2]

During the past two decades in the United States, one in five infant deaths was caused by a birth defect. Other leading causes of infant mortality include preterm delivery, low birthweight, sudden infant death syndrome (SIDS) and respiratory distress syndrome.[3] Nationally, about a third of infant deaths occur after the first month of life.[4]

Infant mortality has two components: neonatal mortality, deaths of infants younger than 28 days, and postneonatal mortality, deaths between 28 days and one year old.[5] From 1997 to 2001, 409 Rhode Island infants died before their first birthday. Of these, 318 (78%) were neonatal deaths and 91 (22%) were postneonatal deaths.[6] Risk factors for infant mortality include lack of prenatal care and preventive care, poverty, poor living conditions, short intervals between pregnancies, inadequate maternal nutrition, smoking, alcohol and substance use, and mothers with less than 12 years of education.[7,8]

During the past decade, the proportion of infant deaths in Rhode Island attributed to maternal health increased from 50% to 63%.[9] Maternal health includes preconceptional health, perinatal care, and health behaviors. Factors contributing to this increase include an increase in the number of very low birthweight infants, an overall increase in premature births, and an increase in multiple gestation births.[10] The growth in multiple births has also contributed to the increase in premature and low birthweight births.[11]

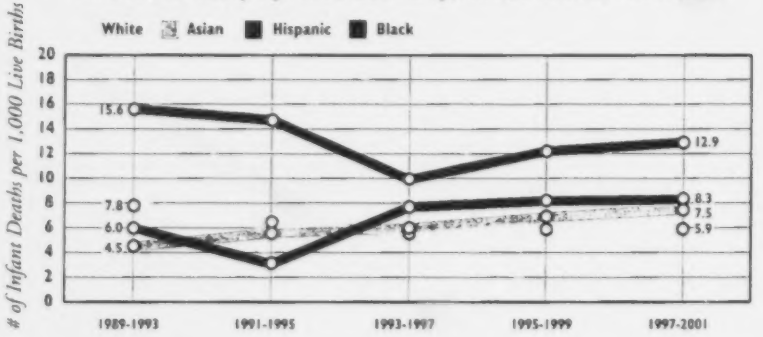
Infant Mortality Rate
(rate per 1,000 live births)

	1990	1999
RI	8.1	5.7
US	9.2	7.1
State Rank		*6th*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles of Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Infant Mortality by Race/Ethnicity, Rhode Island, 1989-2001



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1989-1993, 1991-1995, 1993-1997, 1995-1999 and 1997-2001. Data for 1999-2001 are provisional.

◆ Over the past decade, Rhode Island's infant mortality rate has declined for White and Black infants, but has increased for Hispanic and Asian infants. Infant mortality rates for all racial and ethnic groups except White infants have been gradually rising since 1995. The Black infant mortality rate for 1997-2001 is more than twice the rate for White infants and higher than that of any other racial and ethnic group.[12]

◆ During the 1990s, the infant mortality rate dropped 36% for infants with publicly-funded health insurance coverage and 17% for infants with private health insurance coverage. The gap in infant mortality rates between these two groups of infants was reduced by more than half.[13]

Table 16. **Number of Infant Deaths, Rhode Island, 1997-2001**

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	820	2	2.4
Bristol	1,067	5	4.7
Burrillville	781	4	5.1
Central Falls	1,781	17	9.5
Charlestown	446	1	NA
Coventry	1,924	5	2.6
Cranston	4,171	20	4.8
Cumberland	1,701	15	8.8
East Greenwich	588	3	5.1
East Providence	2,499	13	5.2
Exeter	341	1	NA
Foster	197	3	NA
Glocester	464	2	NA
Hopkinton	488	5	NA
Jamestown	205	0	NA
Johnston	1,492	10	6.7
Lincoln	990	8	8.1
Little Compton	157	1	NA
Middletown	1,083	6	5.5
Narragansett	667	2	3.0
New Shoreham	57	1	NA
Newport	1,645	8	4.9
North Kingstown	1,500	2	1.3
North Providence	1,576	16	10.2
North Smithfield	515	1	1.9
Pawtucket	5,030	44	8.7
Portsmouth	917	5	5.5
Providence	13,589	134	9.9
Richmond	473	0	NA
Scituate	506	2	4.0
Smithfield	805	2	2.5
South Kingstown	1,298	6	4.6
Tiverton	649	1	1.5
Warren	582	4	6.9
Warwick	4,428	29	6.5
West Greenwich	297	1	NA
West Warwick	2,024	10	4.9
Westerly	1,375	7	5.1
Woonsocket	2,980	13	4.4
Unknown	*2*	*0*	*NA*
Core Cities	*27,049*	*226*	*8.4*
Remainder of State	*35,061*	*183*	*5.2*
Rhode Island	*62,110*	*409*	*6.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Rates were not calculated for cities and towns with less than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1997-2001.

References for Indicator

[1,9] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] *KIDS COUNT DATA BOOK: State Profiles in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[3] *Perinatal Profiles: Statistics for Monitoring Maternal and Infant Health* (2003). Washington, DC: March of Dimes.

[5] *Child Health USA 2002* (2002). Rockville, MD: Department of Health and Human Services, Maternal and Child Health Bureau.

[6,14] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

[7] *HHS Fact Sheet: Preventing Infant Mortality* (2001). Washington, DC: US Department of Health and Human Services.

[8] Matthews, T., et al (2002). "Infant Mortality Statistics from the 1999 Period Linked Birth/Infant Death Data Set" in *National Vital Statistics Reports*, Vol.50, No.4.

[9,10,11] Viner-Brown, S., et al (January 2003). "Infant Mortality in Rhode Island: A Time Trend Analysis" in *Medicine & Health / Rhode Island*, Vol. 86, No. 1.

[12] *RI Medicaid Research and Evaluation Reports, Issue Brief #3: Rhode Island's Infant Mortality Rate Drops Significantly in 1990s* (2002). Cranston, RI: Rhode Island Department of Human Services, Center for Child and Family Health.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood lead levels (≥10ug/dL) at any time prior to December 31, 2002. These data are for children eligible to enter kindergarten in the fall of 2004 (i.e., born between September 1, 1998 and August 31, 1999).

SIGNIFICANCE

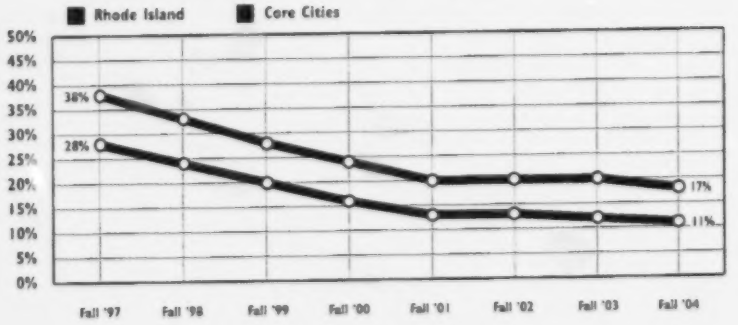
Childhood lead poisoning is one of the most common pediatric health problems, yet it is entirely preventable. Infants, toddlers and preschool age children are most susceptible to the toxic effects of lead and absorb lead more readily than adults.[1] Lead exposure can cause irreversible damage resulting in loss of intelligence, speech delay, learning disabilities, attention deficits and behavioral problems. The most acute poisoning can result in severe illness and death.[2,3] The societal costs of lead poisoning include the loss of lifetime earnings due to decreased cognition as well as medical and special education costs.[4]

All children living in homes built before 1978 – when lead paint was banned from interior use in the United States – are at risk for lead poisoning. Low-income, minority and urban children are particularly likely to be affected.[5,6] Black, Hispanic and Asian children under age 6 screened in 2002 were two to three times as likely as White children to have elevated blood lead levels.[7]

The lack of affordable housing in many communities forces many low-income families to live in older dwellings with deteriorating lead paint, placing children at increased risk for exposure to lead.[8] Inadequate nutrition and anemia, which are more common in low-income children, further increase susceptibility to lead poisoning.[9] Children in older homes undergoing renovation are also at risk.[10]

Rhode Island law requires annual blood lead level screening for all children under age 6. During 2002, 7% of all Rhode Island children under age 6 who were tested for lead exposure had elevated lead levels over 10 ug/dL.[11] Of the 2,462 Rhode Island children with elevated blood lead levels, 823 had lead levels greater than or equal to 15 ug/dL.[12] A single test result of 20 ug/dL or greater or any two tests greater than 15 ug/dL within a 3 to 12 month period trigger a mandatory inspection of the child's home. The Department of Health sends certified lead inspectors to determine whether lead hazards are present and to work with property owners to make the property lead-safe. In Rhode Island in 2002, there were 322 inspections offered; of these, 260 were performed and 62 were refused.[13]

Children Entering Kindergarten with History of Lead Poisoning, Rhode Island and Core Cities, Fall 1997- Fall 2004



Source: Rhode Island Department of Health, Office of Occupational and Radiological Health and Division of Family Health, 1995 - 2002.

◆ The number of children entering kindergarten with a history of lead poisoning has decreased throughout the state as well as in the core cities.[14] Children in the core cities (17%) are still almost three times as likely to have elevated blood lead levels as children in the remainder of the state (6%).[15] Of the 7 children hospitalized for severe lead poisoning during 2002, 5 resided in Providence and 2 in Pawtucket.[16]

◆ In 2002, the Rhode Island legislature passed the Lead Mitigation Act, comprehensive legislation that places a strong emphasis on enforcement mechanisms for lead safety in housing and strengthens tenants' rights. The Lead Mitigation Act strengthens requirements and penalties for timely abatement by landlords, requires timely referral for prosecution in the event adequate abatement is not undertaken, and creates tenant remedies to enforce the provisions of the Act through agency intervention or privately-initiated court action.[17]

◆ The Centers for Disease Control and Prevention recommends a comprehensive, multidisciplinary approach to the treatment of lead poisoning, including repeat blood tests to monitor lead levels, medical management, house inspections, removal of lead hazards, child development and social services, parent education and ongoing monitoring for developmental problems that may arise for children at key transition points such as first grade, fourth grade and middle school.[18,19]

Table 17.

Lead Poisoning in Children Entering Kindergarten in the Fall of 2004

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	211	8	3.8%
Bristol	240	13	5.4%
Burrillville	169	14	8.3%
Central Falls	376	77	20.5%
Charlestown	96	11	11.5%
Coventry	406	17	4.2%
Cranston	825	59	7.2%
Cumberland	423	19	4.5%
East Greenwich	127	7	5.5%
East Providence	492	45	9.1%
Exeter	53	4	7.5%
Foster	50	4	8.0%
Glocester	78	4	5.1%
Hopkinton	103	7	6.8%
Jamestown	45	3	6.7%
Johnston	305	9	3.0%
Lincoln	237	17	7.2%
Little Compton	35	4	11.4%
Middletown	173	14	8.1%
Narragansett	129	6	4.7%
New Shoreham	6	0	0.0%
Newport	345	71	20.6%
North Kingstown	355	23	6.5%
North Providence	273	12	4.4%
North Smithfield	116	8	6.9%
Pawtucket	1,021	136	13.3%
Portsmouth	203	19	9.4%
Providence	2,898	558	19.3%
Richmond	92	5	5.4%
Scituate	136	7	5.1%
Smithfield	163	8	4.9%
South Kingstown	328	28	8.5%
Tiverton	162	19	11.7%
Warren	124	11	8.9%
Warwick	869	43	4.9%
West Greenwich	58	0	0.0%
West Warwick	375	17	4.5%
Westerly	172	21	12.2%
Woonsocket	720	115	16.0%
Unknown Residence	*537*	*18*	*3.4%*
Core Cities	*5,735*	*974*	*17.0%*
Remainder of State	*7,791*	*487*	*6.3%*
Rhode Island	*13,526*	*1,461*	*10.8%*

Lead Poisoning Rates in Rhode Island

◆ In the core cities, 17% of the children who will enter kindergarten in the fall of 2004 have a history of lead poisoning as compared to 38% in the fall of 1997. One in five children entering kindergarten in Central Falls, Newport and Providence has a history of lead exposure.[20]

Source of Data for Table/Methodology

Rhode Island Department of Health, Office of Occupational and Radiological Health and Division of Family Health.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Data for children entering kindergarten in the fall of 2004 reflect the number of RI children eligible to enter school in the fall of 2004 (i.e., born between 9/1/98 and 8/31/99) who screened positive for lead poisoning at any time prior to the end of December 2002. Data include both venous and capillary tests.

The denominator is the number of children entering school in the fall of 2004 who were screened for lead poisoning.

References for Indicator

[1,5] Farley, D. (January-February, 1998). "Dangers of Lead Still Linger" in *FDA Consumer*, Washington, DC: U.S. Food and Drug Administration.

[2,3,4] *Screening Young Children for Lead Poisoning: Guidelines for State and Local Public Health Officials* (November 1997). Atlanta, GA: Centers for Disease Control and Prevention.

[2,6,11] *Managing Elevated Blood Lead Levels Among Young Children* (2002). Atlanta, GA: Centers for Disease Control and Prevention.

[4] *Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[8,9] *2002 Housing Resources Commission Annual Report* (March 2002). Providence, RI: Housing Resources Commission.

[7,10,12,20] Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health. Data are for children entering kindergarten in the fall of 2004 and fall of 1997 (who screened at or above 10 ug/dL at any time up until age three).

[14,15] Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health. Data are for all children under age 6 screened in 2002.

[13,16] Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health. January-December 2002.

[17] The State of Rhode Island General assembly Web site: www.rilin.state.ri.us/PublicLaws/law02/law02188.htm. (February 2003).

Children with Asthma

DEFINITION

Children with asthma is the rate of asthma hospitalizations among children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic lung disease that causes recurrent episodes of wheezing, breathlessness, chest tightness, and cough and can be life threatening.[1,2] Attacks can be triggered by exposure to cigarette smoke, mold and dust in the home, stress, strenuous exercise, allergies, roach infestation, animal dander, indoor and outdoor pollutants, and weather conditions.[3,4] Childhood asthma in the U.S. has steadily increased over the past two decades from 40 per 1,000 children in 1982 to 108 per 1,000 children in 1999.[5,6,7] In 1999 in the United States, for every 10,000 children under age 15 there were 600 asthma outpatient visits, 110 asthma emergency room visits, and 30 asthma hospitalizations.[8]

Asthma is the number one chronic condition in children and the first-ranked cause of hospitalization in children under age 15. Asthma is the leading cause of school absences resulting from chronic illness.[9] Black children are more likely to suffer from asthma than White, non-Hispanic or Hispanic children. Racial differences in the prevalence of asthma are correlated with poverty, substandard housing, urban air quality, indoor allergens and lack of access to preventive medical care.[10,11]

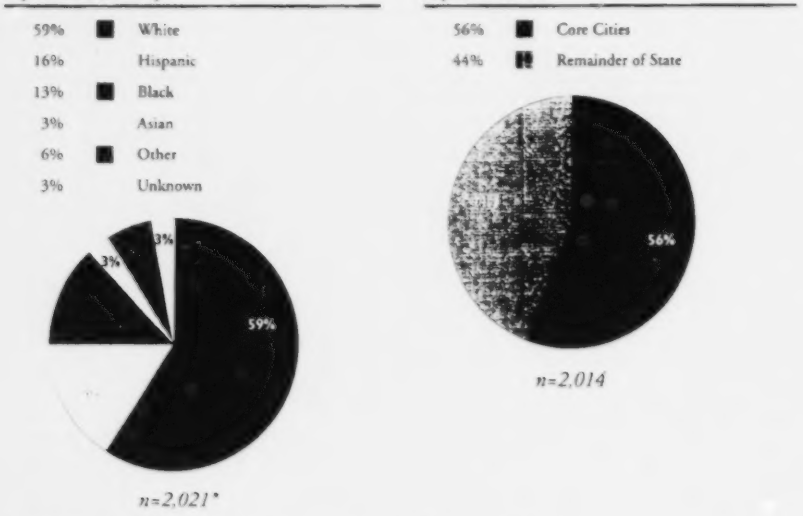
Managing asthma requires a long-term, multifaceted approach, including patient education, behavior modification, avoidance of asthma triggers, medication to minimize and prevent symptoms, prompt treatment and frequent medical follow-up.[12,13] Insured children are twice as likely as uninsured children to receive ongoing asthma care from a physician. Low-income and uninsured children are more likely to receive treatment in the emergency department or be hospitalized for conditions that could have been managed with appropriate outpatient care.[14]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 1999-2001

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Central Falls	61	3.7
Newport	48	3.1
Pawtucket	165	3.0
Providence	656	4.8
West Warwick	65	3.3
Woonsocket	128	3.8
Rhode Island	2,014	2.7

Source: Rhode Island Department of Health, Hospital Discharge Database, 1999-2001.

Asthma Hospitalizations, Children Under Age 18, Rhode Island, 1999-2001



Source: Rhode Island Department of Health, Hospital Discharge Database, 1999-2001.
*Includes 7 non-Rhode Island residents.

Asthma and Access to Health Care

◆ Most cases of childhood asthma can be managed by the child's primary care physician and timely medical care can prevent severe asthma attacks. Hospitalization for asthma may indicate that the child has not had adequate outpatient management of the disease.[15,16] Asthma symptoms not severe enough to require hospitalization may still prevent a child with asthma from leading a fully-active life.[17]

◆ In Rhode Island between 1999-2001, over half (56%) of all hospitalizations for childhood asthma were children residing in the core cities, where only a third of Rhode Island's children live.[18] Rhode Island's core cities have the highest child poverty rates and the highest rates of children without health insurance in the state.[19]

Table 18

Asthma Hospitalizations for Children, Rhode Island, 1999-2001

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	14,235	21	1.5
Bristol	13,197	25	1.9
Burrillville	12,129	23	1.9
Central Falls	16,593	61	3.7
Charlestown	5,136	17	3.3
Coventry	25,167	47	1.9
Cranston	51,294	121	2.4
Cumberland	23,070	29	1.3
East Greenwich	10,692	15	1.4
East Providence	31,638	70	2.2
Exeter	4,767	4	0.8
Foster	3,315	6	1.8
Glocester	7,992	8	1.0
Hopkinton	6,033	9	1.5
Jamestown	3,714	2	0.5
Johnston	17,718	37	2.1
Lincoln	15,471	25	1.6
Little Compton	2,340	2	0.9
Middletown	12,984	42	3.2
Narragansett	8,499	12	1.4
New Shoreham	555	0	0.0
Newport	15,597	48	3.1
North Kingstown	20,544	37	1.8
North Providence	17,808	45	2.5
North Smithfield	7,137	5	0.7
Pawtucket	54,453	165	3.0
Portsmouth	12,987	22	1.7
Providence	135,831	656	4.8
Richmond	6,042	10	1.7
Scituate	7,905	11	1.4
Smithfield	12,057	8	0.7
South Kingstown	18,852	32	1.7
Tiverton	10,101	12	1.2
Warren	7,362	18	2.4
Warwick	56,340	107	1.9
West Greenwich	4,332	7	1.6
West Warwick	19,896	65	3.3
Westerly	16,218	34	2.1
Woonsocket	33,465	128	3.8
Unknown Residence	*NA*	*28*	*NA*
Core Cities	*275,835*	*1,123*	*4.1*
Remainder of State	*467,631*	*891*	*1.9*
Rhode Island	*743,466*	*2,014*	*2.7*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1999-2001.

The data are for fiscal year 1999 and calendar year 2000 and 2001.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the total number of children under age 18 according to the 2000 Census of Population.

References for Indicator

[1] *Asthma in Children Fact Sheet* (2002). New York, NY: American Lung Association.

[2,5,7] *Asthma and the Environment: A Strategy to Protect Children* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[3,4,6] *Minority Lung Disease Data 2000* (2000). New York, NY: American Lung Association.

[4] Vanderslice, R. and Bibeault, L. (July 1999). "Asthma and the Environment: A Physician's Guide to Resources, Research, and Data" in *Medicine and Health/Rhode Island*, Vol. 82, No. 7. Providence, RI: Rhode Island Medical Society.

[5] *Trends in Asthma Morbidity and Mortality* (2002). New York, NY: American Lung Association.

[7] *Asthma in Children Fact Sheet* (1999). New York, NY: American Lung Association.

[8] Mannino, D. et al (March 2002). "Surveillance for Asthma-United States, 1980-1999" in *MMWR*, Vol. 51, No. SS1.

[9] *National Asthma Control Program. Reducing Costs and Improving the Quality of Life, 2002* (2002). Atlanta, GA: Centers for Disease Control and Prevention.

[10,14] *Pediatric Asthma: Promising Best Practice – Guide for Managing Asthma in Children* (1999). Washington, DC: American Academy of Allergy, Asthma, and Immunology.

[12] Sherman, C. and Arthurs, D. (July 1999). "Office Management of Asthma" in *Medicine & Health Rhode Island*, Vol. 82, No. 7.

[13] *No Health Insurance? It's Enough to Make You Sick* (1999). Washington, DC: American College of Physicians-American Society of Internal Medicine.

[15] Rhode Island Department of Health, Hospital Discharge Database, 1999-2001.

[16] Rhode Island Department of Human Services, Medicaid Data Archive and Rhode Island Department of Health, Behavioral Risk Factor Surveillance System, 2002.

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and are less likely to have the financial resources, social supports and parenting skills needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison or become teen parents themselves.[2]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically-disadvantaged families and communities.[3] In the U.S., 83% of teens who give birth are from poor or low-income families.[4] Teen moms are more likely to have mothers who have completed fewer years of schooling and to have mothers or older sisters who also gave birth as adolescents.[5]

Poor academic achievement is a key predictor of teen pregnancy.[6] Nationally, three out of five teen mothers drop out of school. Being a teen parent seriously limits subsequent education and employment prospects.[7] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty.[8]

In Rhode Island between 1997 and 2001, there were 124 births to teens ages 12 to 14; 2,219 births to teens ages 15 to 17; and 4,065 births to teens ages 18 and 19. Between 1997 and 2001 in Rhode Island, 61% of teen pregnancies to girls ages 15 to19 resulted in live births, 36% resulted in abortion, and 3% resulted in miscarriage. In the core cities, 30% of pregnant teens ages 15 to 19 had abortions, compared to 47% of pregnant teens in the rest of Rhode Island. More than one in five (21%) births to teen girls ages 15 to 19 are to girls who have already given birth at least once.[9]

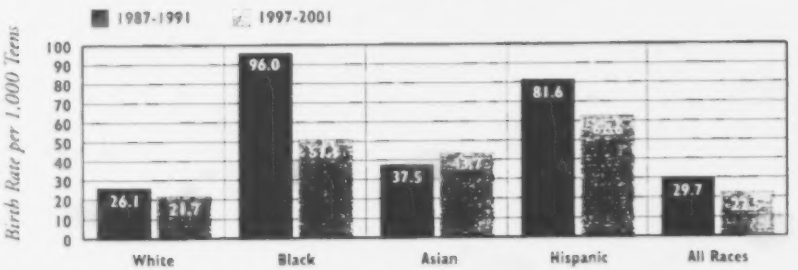
Teen Birth Rate
(births per 1,000 teens ages 15-17)

	1990	1999
RI	32	22
US	37	29
State Rank		*16th*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Births to Teens Ages 15-17, by Race and Ethnicity, Rhode Island, 1987-1991 and 1997-2001



◆ Between the late 1980s and the late 1990s, teen birth rates for Rhode Island girls ages 15 to 17 declined for all racial and ethnic groups except Asian, which increased by 17%. The rate for Black teens decreased by nearly 50%, compared to a 23% decrease for Hispanic teens, and a 17% decrease for White, non-Hispanic teens.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1997-2001. Data for 1999-2001 are provisional.

Repeat Births to Teens, Ages 12 to 19, Rhode Island, 1997-2001

Age	Total Number of Births	Number of Repeat Births	Percent
12-14	124	1	<1%
15-17	2,219	215	10%
18-19	4,065	1,077	27%
Total	6,284	1,292	21%

◆ Between 1997 and 2001 in Rhode Island, one in five teen births (21%) was to a teen who was already a mother. For girls ages 15-17, 10% of births were repeat births and for girls ages 18-19, more than one in four (27%) were repeat births.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Table 19.

Births to Teens, Ages 15-17, Rhode Island, 1997-2001

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	1997-2001 RATE PER 1,000 TEENS
Barrington	2,130	3	1.4
Bristol	1,860	18	9.7
Burrillville	1,785	16	9.0
Central Falls	1,875	112	59.7
Charlestown	670	11	16.4
Coventry	3,210	45	14.0
Cranston	6,890	103	14.9
Cumberland	3,125	27	8.6
East Greenwich	1,415	4	2.8
East Providence	4,565	55	12.0
Exeter	725	7	9.7
Foster	445	4	NA
Glocester	1,145	6	5.2
Hopkinton	870	12	13.8
Jamestown	565	2	3.5
Johnston	2,295	18	7.8
Lincoln	2,190	12	5.5
Little Compton	295	0	NA
Middletown	1,370	10	7.3
Narragansett	1,265	9	7.1
New Shoreham	80	0	NA
Newport	1,990	61	30.7
North Kingstown	2,660	16	6.0
North Providence	2,470	35	14.2
North Smithfield	1,015	8	7.9
Pawtucket	6,820	224	32.8
Portsmouth	1,680	8	4.8
Providence	17,055	939	55.1
Richmond	815	10	12.3
Scituate	1,215	8	6.6
Smithfield	1,750	12	6.9
South Kingstown	2,750	22	8.0
Tiverton	1,345	11	8.2
Warren	1,000	11	11.0
Warwick	7,910	91	11.5
West Greenwich	540	3	5.6
West Warwick	2,455	63	25.7
Westerly	2,170	33	15.2
Woonsocket	4,240	190	44.8
Core Cities	*34,435*	*1,589*	*46.1*
Remainder of State	*64,215*	*630*	*9.8*
Rhode Island	*98,650*	*2,219*	*22.5*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999–2001 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Rates were not calculated for cities and towns with less than 500 teen girls ages 15-17, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 2000 Census of Population, multiplied by five to compute a rate over five years, 1997-2001.

References for Indicator

[1] *KIDS COUNT Data Book: State Profiles in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[2] *The State of America's Children Yearbook 2001* (2001). Washington, DC: Children's Defense Fund.

[3a] *When Teens Have Sex: Issues and Trends* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[4] *Facts in Brief: Teen Sex and Pregnancy* (1999). New York, NY: Alan Guttmacher Institute.

[5] *Why the Education Community Cares About Preventing Teen Pregnancy: Notes From the Field* (2002). Washington, DC: National Campaign to Prevent Teen Pregnancy.

[6] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2001. Data for 1999-2001 are provisional.

Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol or marijuana in the past month or are current smokers. Seventh-grade data are taken from the *2001 Youth Tobacco Survey*. Ninth and twelfth-grade data are taken from the *2001 Rhode Island Youth Risk Behavior Survey*.

SIGNIFICANCE

While the number of adolescents using drugs and tobacco is slowly decreasing both in Rhode Island and nationwide, youth are starting to use alcohol, tobacco and illicit drugs at increasingly younger ages.[1,2,3,4] The age when young people first start using alcohol, tobacco and illicit drugs is a predictor of later alcohol and drug problems, especially if use begins before age 15.[5]

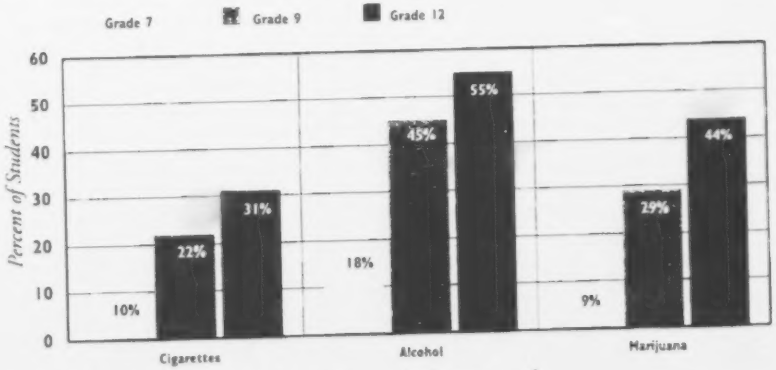
The use of substances threatens the health and safety of children, families, and communities. Of the more than 2 million deaths each year in the United States, approximately one in four is attributable to alcohol, tobacco and illicit drug use.[6] Substance use can result in family violence and mistreatment of children.[7] Prenatal exposure to alcohol, tobacco, or drugs *in utero* is linked to psychological, cognitive, and physical problems in children.[8]

Children who are not engaged in school, have high rates of school failure, lack connections with caring adults, and have feelings of peer rejection are at increased risk of substance abuse during adolescence.[9,10,11] For both cigarette and alcohol use, the greatest risk factors among youths are frequent problems with school work and the number of friends who either smoke or drink regularly.[12]

Tobacco use is the chief preventable cause of death in the United States.[13] If current smoking patterns continue, an estimated 5 million children and youths alive today will die prematurely of a smoking-related disease, of which 23,500 will be from Rhode Island.[14,15] Tobacco use among adolescents is a predictor of other drug use, especially among females.[16]

According to the National Institute on Drug Abuse, drug treatment reduces use by 40 to 60 percent.[17] Social skills training has been shown to reduce substance use in early adolescents.[18] Family and friends play critical roles in motivating substance abusers to enter treatment and maintain sobriety.[19]

Use of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 2001



Student has used cigarettes, alcohol, or marijuana in the past month.

Sources: Seventh-grade data are from the *2001 Youth Tobacco Survey*, Rhode Island Department of Health, Office of Health Statistics. Ninth and twelfth-grade data are from the *2001 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Office of Health Statistics.

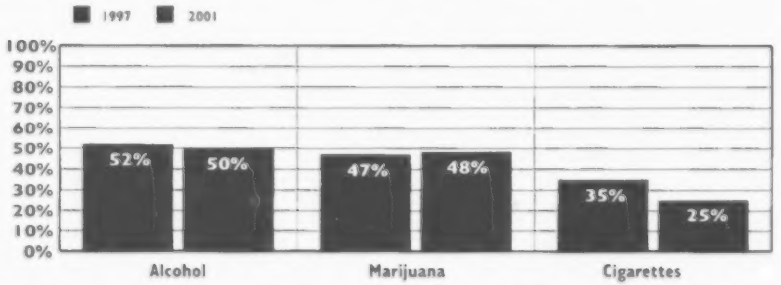
◆ In Rhode Island, nearly half (45%) of students have used alcohol by 9th grade and almost one in five (18%) have used alcohol by 7th grade.[20] Research indicates that more than 40% of those who start drinking at age 14 or younger will develop alcohol dependence.[21]

◆ More than one out of four sexually-active teenagers in Rhode Island used alcohol or drugs before their last sexual intercourse.[22] Teens who use alcohol are seven times more likely to have sex than teens who do not and are more likely to have sex at a younger age.[23] These teens are at greater risk of sexually-transmitted infections and/or becoming pregnant.[24]

◆ Binge drinking, defined as having five or more drinks in a row within a few hours, puts children at greater risk of school failure, suicide attempts or suicidal thoughts, and entrance into the juvenile justice system.[25] In 2001, 31% of Rhode Island teens reported binge drinking in the past 30 days. Of this group, almost half were age 15 or younger.[26]

Alcohol, Drug, and Cigarette Use by Teens

Alcohol, Marijuana and Cigarette Use Among High School Students, Rhode Island, 1997 and 2001



Student has used cigarettes or alcohol in the past month. Student has used marijuana during lifetime.

Source: *1997 Rhode Island Youth Risk Behavior Survey* (1997) and *2001 Rhode Island Youth Risk Behavior Survey* (2001). Rhode Island Department of Health, Office of Health Statistics.

◆ Drug and alcohol use among teenagers is generally decreasing nationwide.[27,28,29] In Rhode Island, substance use in high school has leveled off or declined since 1997.[30,31]

◆ According to the SALT Survey for the 2001-2002 school year, just over one in ten (12%) middle school students reported being offered drugs at school.[32] Almost one in five (19%) high school students reported peer pressure to use drugs or tobacco.[33]

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Prevention and Treatment to Combat Teen Drug Use

◆ Rhode Island received a $9 million State Incentive Grant from the federal Center for Substance Abuse and Prevention to prevent and treat teen drug use. The State Incentive Grant has three major goals: to develop a comprehensive state prevention plan; to measure progress in reducing alcohol, tobacco and other drug prevalence among youth aged 12 to 17; and to coordinate, leverage and/or redirect substance abuse prevention funding. The grant is administered by the Rhode Island Department of Mental Health, Retardation and Hospitals.[34]

References for Indicator

[1,27] Johnston, L. D., O'Malley, P.M., and Bachman, J. G. (2002). *Monitoring the Future National Results on Adolescent Drug Use: Overview of Key Findings, 2001.* Bethesda, MD: National Institute on Drug Abuse.

[2,28,31,32,33] *SALT Survey: Rhode Island State Report, 2001-2002* (2002). Providence, RI: National Center on Public Education and Social Policy, University of Rhode Island.

[3,13,19,22,28,29,30] *2001 Rhode Island Youth Risk Behavior Survey.* Rhode Island Department of Health, Office of Health Statistics.

[4,5,6,7,8,14,15,21] *Substance Abuse: The Nation's Number One Health Problem* (February 2001). Prepared by the Schneider Institute for Health Policy at Brandeis University for The Robert Wood Johnson Foundation. Princeton, NJ: The Robert Wood Johnson Foundation.

[8,12] Blum, R.W., Beuhring, T., and Rinehart, P.M. (2000). *Protecting Teens: Beyond Race, Income and Family Structure.* Minneapolis, MN: Center For Adolescent Health and The Robert Wood Johnson Foundation.

[11] Whitaker, L. (2001). "Substance Abuse Prevention: What Works and What Doesn't" *in Advances*, Issue 2. The Robert Wood Johnson Foundation.

[11,18] "Substance Abuse: Predicting It, Preventing It" in *SAMHSA News*, Vol. IX, No. 2. (Spring 2001).

[15] *Investment in Tobacco Control: State Highlights* (2001). Atlanta, GA: Centers for Disease Control and Prevention, Office on Smoking and Health.

[17] *Alcohol, Other Drugs, and Child Welfare Highlights* (2001). Washington, DC: Child Welfare League of America.

[19] *Principles of Drug Addiction Treatment: A Research-Based Guide* (2000). Washington, DC: U.S. Department of Health and Human Services, National Institute on Drug Abuse, National Institutes of Health.

[23,25] *Teen Tipplers: America's Underage Drinking Epidemic* (February 2002). New York, NY: The National Center on Addiction and Substance Abuse at Columbia University.

[24] *Substance Use and Risky Sexual Activity* (February 2002). New York, NY: The National Center on Addiction and Substance Abuse at Columbia University.

[34] Rhode Island's State Incentive Grant (2002). Rhode Island Department of Mental Health, Retardation and Hospitals, Division of Behavioral Health Care.

Additional Children's Health Issues

Adolescent Health Issues

Adolescents disproportionately engage in risky behaviors. As a result, these youth place themselves at greater risk of both immediate and long-term health consequences.

Health Risks and Risk Behavior Among Rhode Island Public High School Students, 2001

Driving and Alcohol	
Rode in a vehicle during the past 30 days driven by someone who had been drinking alcohol	32%
Drove a vehicle during the past 30 days after drinking alcohol	14%
Suicide	
Attempted suicide during the past 12 months	8%
Planned a suicide attempt during the past 12 months	12%
Sexual Behavior	
Ever had sexual intercourse	46%
Initiated sexual intercourse at age 13 or younger	12%
Did not use a condom during last sexual intercourse*	39%
Used drugs or alcohol before last sexual intercourse**	27%
Girls who had ever been forced to have sexual intercourse	8%

Source: *2001 Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health.*
*Question only asked for students who had sexual intercourse during the 3 months prior to the survey.
**Question only asked for sexually-active students.

Safety in Schools

◆ During the 2001-2002 school year in Rhode Island, 8% of middle school students and 8% of high school students reported experiencing violence in school. Over one-third of middle school students and over one-fourth of high school students reported fear of being hurt or bothered at school.[1] In 2001, 11% of high school students reported carrying a weapon to school.[2]

Access to Health Care in Schools

◆ In Rhode Island, an estimated 7,000 school-age children ages 6 to 18 have no health insurance.[3]

◆ Even teens with health insurance can have limited access to health care services. In 2001, half (51%) of the children and youth ages 12 to 21 who participated in the Neighborhood Health Plan of Rhode Island managed care plan did not receive a well-child visit.[4]

◆ Health care provided in schools can increase children's access to important prevention and treatment services. School-based health centers (SBHCs) are clinical primary health care sites located within schools. SBHCs offer comprehensive physical and mental health services such as treatment of colds, care for chronic conditions such as asthma and diabetes, mental/behavioral health services, substance abuse services, physical and sports examinations, reproductive health care, dental care, and immunizations. Services are free for students without health insurance.[5]

◆ SBHCs provided nearly 9,500 services to children during the 2001-2002 school year.[6] Of these, 755 were behavioral health services. This was 1,339 fewer behavioral health services than the previous year, due in part to a lack of providers.[7] Behavioral health services in schools can increase a student's ability to receive necessary social and emotional treatment and support.

References

1. *SALT Survey: Rhode Island State Report, 2001-2002* (2002). Providence, RI: National Center on Public Education and Social Policy, University of Rhode Island.
2. *2001 Youth Risk Behavior Survey* (2002). Providence, RI: Rhode Island Department of Health.
3. US Census Bureau, Current Population Survey, 2000-2002 average.
4. *Neighborhood Health Plan of Rhode Island, HEDIS 2002 Results: Adolescents Well-Care Visits* (2002). Providence, RI: Neighborhood Health Plan of Rhode Island.
5. *School Based Health Center Services Help Teens Stay in School* (February 1999). Health Policy Briefs issue 99-2. Providence, RI: Rhode Island Department of Health.
6. Rhode Island Department of Health, Adolescent and Young Adult Health Unit (2002).

Overweight Children and Youth

◆ According to the Centers for Disease Control and Prevention, children and youth are considered overweight if their weight is above the 95th percentile for their height, age and gender. Children between the 85th and 95th percentiles are considered "at risk" for overweight.[1]

◆ Overweight in children ages 6 to 19 tripled between the early 1960s and 2000.[2] During the same time period, severe overweight almost doubled in children ages 6 to 11 and increased 64% in youth ages 12 to 17.[3]

◆ During 1999-2000 in the US, 15% of children ages 6 to 19 were overweight and another 15% were at risk for being overweight.[4] During 2001 in Rhode Island, 9% of high school students were overweight.[5]

◆ The prevalence of overweight is highest in Hispanic, Black and Native American children.[6] Children with overweight mothers, low family income, and lower levels of cognitive stimulation also have significantly elevated risk of becoming overweight.[7]

◆ Weight gain occurs when more calories are consumed than are expended.[8] On average, overweight children do not consume significantly more calories than their normal weight peers, but demonstrate a slow, consistent weight gain over several years.[9]

◆ Less than 10% of overweight in children is caused by genetic or hormonal problems.[10] Instead, most children become overweight through excessive inactivity, especially television viewing, in combination with consumption of large portions of energy-dense foods.[11]

◆ Overweight causes hypertension, heart disease, stroke, asthma, sleep apnea, type II diabetes, and orthopedic problems.[12,13] Of particular concern, the rate of type II diabetes in children, historically an adult disease, increased five-fold over the past decade.[14] Overweight children are susceptible to psychosocial problems that include depression, low self-esteem and negative self-image.[15]

Schools, Families, and Communities: Preventing Overweight Children

◆ The likelihood that overweight will persist into adulthood increases with the child's age and severity. Between 70% and 80% of overweight adolescents will remain so as adults.[16] Reducing the number of Rhode Island children who are overweight will require a comprehensive, multi-system approach shared among schools, families and communities.

◆ Pediatricians and other health care providers play a key role in early detection and intervention with overweight children. Physician-supervised treatment plans should include a moderate weight loss goal, attention to dietary management, a gradual increase in physical activity and long-term follow up.[17]

◆ Schools can get involved by integrating behavior-focused nutrition education into their curriculum, serving a variety of healthy foods, and increasing opportunities for physical activity with fitness programs, enhanced playgrounds and extracurricular activities.[18]

◆ Family involvement is critical to preventing and reducing overweight in children. Parents who model healthy eating and exercise, encourage physical activity and limit television viewing can significantly improve their children's health.[19]

References

[1] *Body Mass Index-for-Age* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

[2] *Prevalence of Overweight Among Children and Adolescents: United States, 1999-2000* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

[2,6,9,12,16,17] Moran, R. (February 1999). "Evaluation and Treatment of Childhood Obesity" in *American Family Physician*, Vol. 2, No. 15.

[4] *Obesity Still on the Rise, New Data Show* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

[5] *Youth Risk Behavior Survey 2001* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

[7] Strauss, R. and Knight, J. (June 1999). "Influence of the Home Environment on the Development of Obesity in Children" in *Pediatrics*, Vol. 103, No. 6.

[8] *Rhode Island Obesity Control Program: A Public Health Approach to Addressing Overweight and Obesity Among Children and Adults* (August 2002). Providence, RI: Rhode Island Department of Health.

[11,12,13,15] Ebbeling, C. et al (August 2002). "Childhood Obesity: Public Health Crisis, Common Sense Cure" in *The Lancet*, Vol. 360.

[13] *Endocrinology, Nutrition, and Growth Branch: Report to the NACHHD Council* (September 2000). Rockville, MD: National Institute of Child Health & Human Development.

[14] American Diabetes Association (March 2000). "Type 2 Diabetes in Children and Adolescents" in *Diabetes Care*, Vol. 23, No. 3.

Child Deaths

DEFINITION

Child deaths is the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The child death rate is a reflection of the physical, mental and emotional health of children, the dangers to which children are exposed in the community, access to and use of safety devices and practices (such as bicycle helmets and smoke alarms), and the level of adult supervision children receive.[1] Between 1997 and 2001 in Rhode Island there were 154 child deaths of children ages 1 to 14. Of these, 68% (104) were due to disease, 27% (41) were due to unintentional injuries and 6% were due to intentional injuries (9 homicides, 0 suicides).[2]

Unintentional injuries are the leading cause of death for children ages 1 to 14 in Rhode Island and nationally, exceeding deaths from any single disease.[3] The 50 injury deaths to children ages 1 to 14 in Rhode Island between 1997 and 2001 were due to motor vehicle collisions (12), fire (11), homicides (9), drowning (6), choking (4), and other (8).[4] Unintentional injuries and deaths due to such injuries disproportionately affect poor children, young children, males, rural children, children in families with low levels of education and employment, children with developmental disabilities and minority children.[5] In the U.S., the death rate for Black children ages 1 to 4 is almost twice that for White children.[6]

Many of the injuries that do not result in death are extremely costly both financially and in terms of loss of quality of life. Injuries may leave children temporarily or permanently disabled, result in time lost from school, decrease the child's ability to participate in everyday activities, and affect future ability to work and be independent.[7]

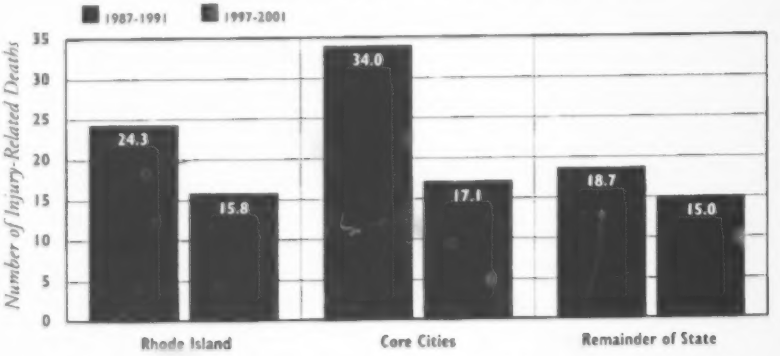
Child Death Rate
(per 100,000 Children Ages 1-14)

	1990	1999
RI	24	20
US	31	24
State Rank		*7th*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Deaths of Children Ages 1 – 14, Rhode Island, Core Cities and Remainder, 1987-1991 and 1997-2001



Source: Rhode Island Department of Health, Maternal and Child Health Database, 1987-1991 and 1997-2001.

◆ Between 1997 and 2001, Rhode Island's six core cities had a child death rate of 17.1 per 100,000 children ages 1 to 14, as compared with 34.0 child deaths per 100,000 between 1987 and 1991.[8]

◆ Motor vehicle accidents are a leading cause of injury deaths to children ages 1 to 14 in Rhode Island and nationally.[9] In the U.S., 47% of motor vehicle occupants ages 1 to 4, and more than 65% of motor vehicle occupants ages 5 to 14, who were killed in fatal crashes in 1999 were not properly restrained in a car seat or seat belt.[10]

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The main threats to adolescents' health and safety are risk behaviors, including substance abuse and violence. The emotional health of teens is linked to teen safety. Risk factors for teens include poverty, diminished economic opportunity, neighborhood violence and academic failure. An important factor which protects against risk behaviors is the presence of strong positve relationships with parents, family or other caring adults and engagement in school.[11,12]

Nationally and in Rhode Island, the two leading causes of death for teens ages 15 to 19 are motor vehicle traffic collisions and firearm deaths.[13,14] Between 1997 and 2001, 44% of Rhode Island's teen deaths were due to unintentional injuries. Of the 76 teen deaths due to unintentional injuries, 67% (51) were due to motor vehicle collisions.[15] Rhode Island youth surveys reveal that 18% of youth do not use safety belts and that 32% frequently combine alcohol consumption with driving.[16]

Teen Deaths by Accident, Homicide and Suicide,
(deaths per 100,000 teens ages 15-19)

	1990	2000
RI	35	25
US	71	53
State Rank		*2nd*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2002* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Injury Deaths to Teens Ages 15 – 19

◆ Between 1997 and 2001, the leading causes of death due to injuries for Rhode Island teens ages 15 to 19 were motor vehicle collisions (51 deaths), homicide (27 deaths), and suicide (20 deaths).[17]

Gun Violence

◆ Between 1997 and 2001 in Rhode Island there were 28 gun deaths to teens ages 15 to 19 and 5 gun deaths involving children age 14 and younger.[18] In addition, 60 children were hospitalized with gunshot wounds. Of these, 7 of the victims were younger than age fifteen and 43 were the victims of intentional injuries (assault or self-inflicted).[19]

◆ Gun violence disproportionately affects the poor and imposes significant medical, law enforcement and other costs on society as a whole.[20] In Rhode Island between 1997 and 2001, 63% of gun injuries to all children occurred in Providence.[21]

References for Indicators

[1] Childhood Injury Fact Sheet (July 1999). Washington, D.C.: Centers for Disease Control and Prevention.

[2,3,5,6,7,8] Rhode Island Department of Health, Maternal and Child Health Database, 1997-2001.

[4] Childhood Injury Fact Sheet (2000). Washington, D.C.: National Safe Kids Campaign

[9,10,11] America's Children: Key National Indicators of Well-Being (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[12] Miller, T.R., Romano, E.O., Spicer, R.S. (Spring/Summer 2000). "The Cost of Childhood Injuries and the Value of Prevention" in The Future of Children, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[13] Resnick, et al (September,1997) "Protecting Adolescents from Harm. Findings from the National Longitudinal Study on Adolescent Health" in Journal of American Medical Association, Vol. 10, pp. 823-32.

[14] "Youth Violence in the United States" (Fact Sheet) (January 2000). Atlanta, GA: Centers for Disease Control and Prevention.

[15] 2001 Rhode Island Youth Risk Behavior Survey (2002). Providence, RI: Rhode Island Department of Health.

[16,21] Rhode Island Department of Health, Hospital Discharge Database, 1997-2001.

[20] Cook, P. et al (Summer/Fall 2002). "The Costs of Gun Violence Against Children" in The Future of Children, Vol. 12, No.2. Los Altos, CA: Center for the Future of Children, the David and Lucille Packard Foundation.

Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at homeless shelters and domestic violence shelters between July 1, 2001 and June 30, 2002.

SIGNIFICANCE

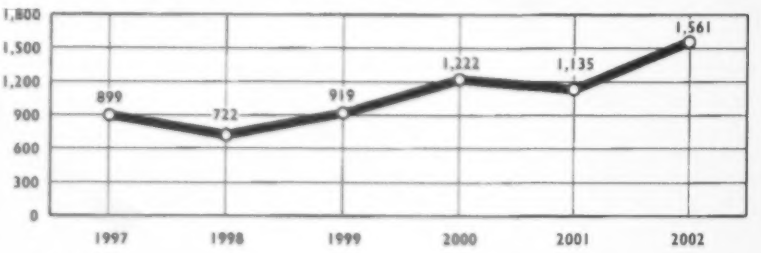
Poverty, low wages, lack of affordable housing and domestic violence are factors in family homelessness.[1,2,3] With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[4] In Rhode Island, the average monthly rent for a two-bedroom apartment is $863. To be considered affordable, this rent would require an annual income of $34,520, or an hourly wage of $16.60 working full-time.[5] This is nearly three times the state's minimum wage of $6.15 per hour.

The shortage of affordable apartments and the dwindling availability of subsidized housing have caused many Rhode Island families to double-up, resulting in overcrowded, unstable living conditions. More than a third of families (40%) with children in the Rhode Island shelter system had been doubled up with family members or friends just before moving to the shelter.[6] Of the 12,000 families enrolled in the Family Independence Program in December of 2002, 30% (3,563) lived in another person's home or apartment either temporarily or permanently at the time that they applied for FIP.[7]

Family homelessness in the United States has increased during the last 15 years.[8] In the U.S., 41% of the homeless are families with children.[9,10] Homeless children are more likely to get sick, have poor nutrition, develop mental health problems, have academic problems, and experience violence than children who are not homeless.[11] Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[12]

Between July 1, 2001 and June 30, 2002, an all time high of 1,692 children under age 18 received shelter from Rhode Island's emergency shelter system.[13] More than half, 974 were age 5 or under, 587 (35%) were ages 6 to 12, and 131 (8%) were ages 13 to 17.[14] Youth between the ages of 13 and 17 are only admitted into the emergency shelter system with adult supervision. Nearly three out of four families (72%) entering the emergency shelter system were headed by a single parent, and 92% of families with children had income below $15,000 per year.[15] The average length of stay in shelters was 34 nights in 2002 and one of every two shelter users (46%) had been turned away from a shelter at least once in the last year.[16]

Children Under Age 13 Living in Shelters, Rhode Island, 1997 – 2002



Source: Rhode Island Emergency Shelter Information Project Annual Reports FY 1997 – FY 2003. Providence RI: Emergency Food and Shelter Board.

◆ 1,561 children under age 13 received emergency housing in a homeless shelter or a domestic violence shelter in Rhode Island between July 1, 2001 and June 30, 2002.

Homeless Children and Education

◆ Children who are homeless are more likely to repeat a grade or be suspended. Homeless children are more likely to be learning disabled, but are less likely to receive treatment for their learning disabilities and less likely to receive special education services.[17]

◆ In 2002 Congress reauthorized the McKinney-Vento Homeless Assistance Act to ensure that all homeless children (including preschool children) and youth have equal access to the same free, appropriate education provided to other children and youth. This includes children who are doubled up with friends and relatives, those who are staying in a motel or campground, those who are living in emergency or transitional shelters, and many other living situations.[18]

◆ The Act allows children to remain enrolled in their school of origin the entire time they are homeless, to receive assistance from the school district in obtaining immunization records, and to be provided transportation to and from school, paid for by the school.[19] The McKinney-Vento Act also requires that each school district designate a homeless liaison to identify children living in homeless situations and remove policies and practices that act as barriers to school enrollment, attendance and success for homeless children.[20]

Homeless Youth

DEFINITION

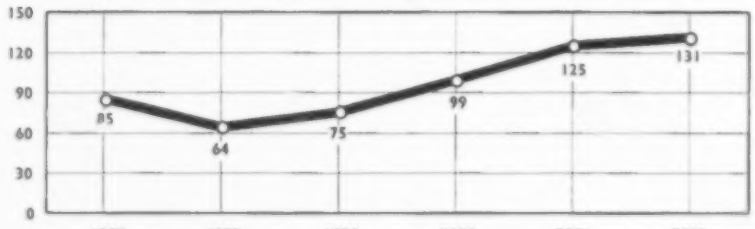
Homeless youth is the number of Rhode Island youth ages 13 to 17 who are homeless or at risk for homelessness, have run away from home, or have been thrown out of their home and not allowed to return.

SIGNIFICANCE

Homelessness among youth has a number of causes, including family problems (such as strained relationships and physical abuse), family homelessness, and residential instability resulting from foster care and institutional placements.[21] Some runaway youth are considered to be throw-aways who were told or forced to leave a household, or were abandoned or deserted by their parents or guardians.[22] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[23]

Although estimates vary, it is projected that there are between 1 million and 1.3 million U.S. youth who run away from home each year.[24] Rhode Island does not have an overnight shelter for runaway youth.

Homeless Youth Ages 13 - 17 in Rhode Island's Emergency Shelter System, 1997-2002



Source: Rhode Island Emergency Shelter Information Project Annual Reports FY 1997 – FY 2002. Providence RI: Emergency Food and Shelter Board.

◆ 131 youth entered the Rhode Island emergency shelter system accompanied by a parent or another adult. This is a 54% increase since 1997. This is an underestimate of homeless youth in the state because the emergency shelter system in Rhode Island does not accept unaccompanied children over the age of 12.[25]

◆ During 2002, 458 Rhode Island youth ages 13 to 17 accessed crisis management services offered by Traveler's Aid and 1,178 calls were made to the Traveler's Aid SAFELINE for runaway youth.[26] In 2002 the National Runaway Switchboard received 248 calls, and the Covenant House hotline received 47 crisis calls from youth in Rhode Island.[27,28]

Department of Children Youth and Families

◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting permanent foster care placement, a group home/treatment placement, or who have run away from their current placement. During 2002, 487 children and youth were in night-to-night placement at some point during the year, an average of 18 per week.[29]

◆ As of December 31, 2002, there were 112 individuals under age 19 in DCYF care who were classified as unauthorized absence/runaways.[30]

References for Indicators

[1,2,3] "Homeless Families with Children" *NCH Fact Sheet #7* (June 2001) Washington, DC: National Coalition for the Homeless.

[4,5,6,7] *Homeless Children: America's New Outcasts* (1999). Newton, MA: The Better Homes Fund.

[8] *A Status Report on Hunger and Homelessness in America's Cities* (2003). Washington, DC: U.S. Conference of Mayors.

[9] Rhode Island KIDS COUNT calculations using data from the Rhode Island Housing and Mortgage Finance Corporation, 2002 Annual Rent Survey. Rents greater than 30% of income are considered unaffordable.

[10] Rhode Island Department of Human Services, InRhodes Database, December 2002.

[11,12,13,14,15] *Rhode Island Emergency Shelter Information Project Annual Report, July 1, 2001-June 30, 2002* (2003). Providence, RI: RI Emergency Food and Shelter Board.

[16] *Homeless in America: A Children's Story, Part One* (1999). New York, NY: Homes for the Homeless and The Institute for Children and Poverty.

[17,18,19,20] "McKinney-Vento 2001 Reauthorization - At a Glance", National Coalition for the Homeless www.nationalhomeless.org, February 2003.

[21] *NCH Fact Sheet #11: Homeless Youth* (1999). Washington, DC: National Coalition for the Homeless.

[22] Son, A. Jia (May 2002). *Information Packet: Runaway and Homeless Youth*. New York, NY: National Resource Center for Foster Care Permanency and Planning at the Hunter College School of Social Work.

[23] *Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). Washington, DC: U.S. Department of Health and Human Services.

[24] "How many young people run away from home each year?", The Administration for Children and Families, Family and Youth Services Bureau, February 2003.

[26] Travelers Aid, Providence, RI, Year-End Reports, 2002.

[27] National Runaway Switchboard, 2002 Region 1 Statistics, www.nrscrisisline.org.

[28] Covenant House, Year End Nine-line Statistics, FY2002.

[29,30] Rhode Island Department of Children, Youth and Families, December 2002.

Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

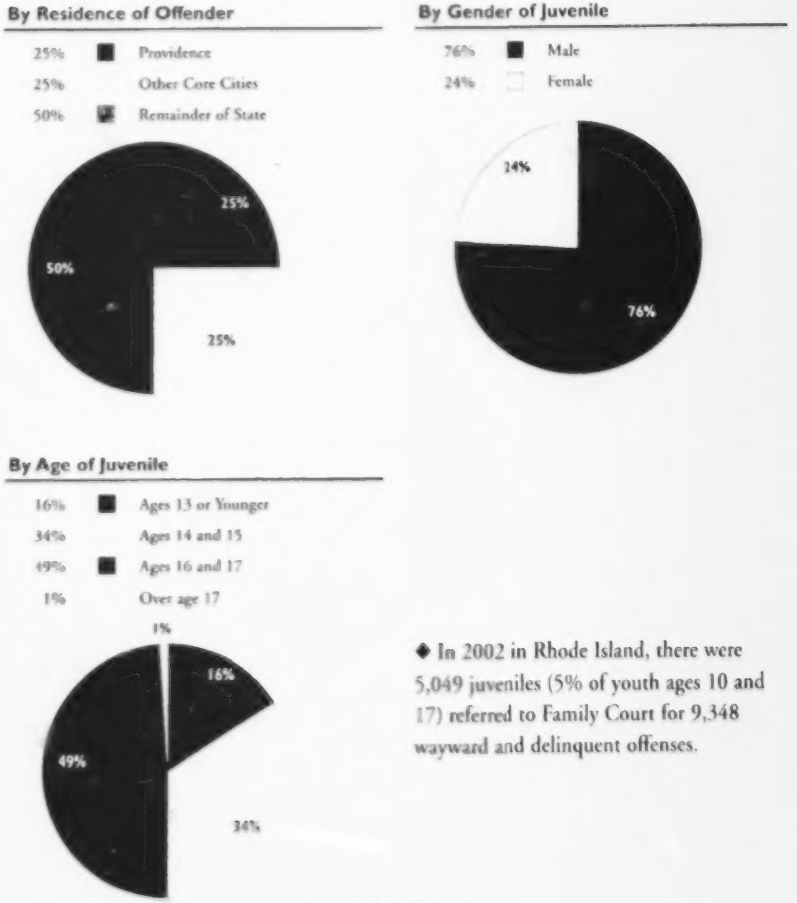
Youth risk factors for involvement in the juvenile justice system and for juvenile violent crime include poverty and diminished economic opportunity, family violence, parental substance abuse, youth substance abuse, mental health problems, truancy, learning disabilities, poor school performance, aggression and association with other high-risk youth.[1,2] During 2002 in Rhode Island, 5,049 youth were referred to Family Court. Most of the offenses were committed by White youth (60%), followed by Black (16%), Hispanic (12%), and Asian (2%).[3]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. In Rhode Island in 2002, only 5% (469) of the 9,348 wayward/delinquent offenses for which juveniles were referred to Family Court involved violent offenses.[4] Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. Juveniles who commit crimes involving drugs may be referred by the Family Court to the Juvenile Drug Court, rather than proceeding through the regular juvenile court system. Juveniles referred to the Drug Court undergo a six- to twelve-month program that includes intensive court supervision, drug treatment, school performance reviews, job placement, and development of social skills and interests outside the drug culture.[5]

Rhode Island Family Court also administers 27 Juvenile Hearing Boards serving 29 communities and permitting the diversion of juveniles accused of status offenses or misdemeanors. Sanction options in this diversion process include community service, restitution, mental health or substance abuse counseling, and/or a community-based program.[6] In 2002, 791 referrals were made to Juvenile Hearing Boards.[7]

Just over one in ten (12%) juveniles referred to Family Court for wayward, delinquent and probation violations in 2002 had been referred to Family Court at least twice before.[8] Prevention, early intervention and positive youth development programs are the most cost-effective approaches to reducing delinquency and recidivism. Successful programs involve highly-trained counselors who work with youth, their families and teachers to promote responsible behavior, implement systems of support and build on strengths.[9,10]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, Rhode Island, 2002



◆ In 2002 in Rhode Island, there were 5,049 juveniles (5% of youth ages 10 and 17) referred to Family Court for 9,348 wayward and delinquent offenses.

n=9,348 offenses

Source: Rhode Island Family Court, Juvenile Offense Report, 2002

Still Night Thoughts

Moonlight in front of my bed-
I took it for frost on the ground!
I lift my eyes to watch the mountain moon,
Lower them and dream of home.

Li Po

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 2002

29%	Property Offenses	9%	Traffic Offenses
14%	Status Offenses*	5%	Violent Crimes
14%	Disorderly Conduct	2%	Weapons Offenses
12%	Simple Assault	5%	Other**
10%	Alcohol and Drugs		

n = 9,348

**Status offenses are age-related violations that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as conspiracy, crank/obscene phone calls, escapes from custody, and other offenses.*

Source: Rhode Island Family Court, Juvenile Offense Reports for 2002.

28

Girls in the Juvenile Justice System

◆ Nationally, between 1991 and 2000, juvenile arrests of females increased more than male arrests in most offense categories.[11] Studies suggest that there has not been a significant increase in female behavior but rather a change in the response of the justice system. Most girls in the juvenile justice system are non-violent offenders charged with relatively minor status, property and drug offenses.[12]

◆ Many delinquent girls have been affected by sexual and physical abuse, familial substance abuse and domestic violence. Girls often use drugs and alcohol to numb the pain of such childhood trauma. Girls in the juvenile justice system have unique developmental, physical and emotional needs that are not met by current programs, which usually are designed for males.[13]

◆ In Rhode Island, DCYF and the Rhode Island Juvenile Justice Commission have formed an Advisory Committee, now in its second year, to assess the adequacy and availability of gender-specific services for court-involved girls and girls at risk of incarceration. Key goals are to address the consequences of victimization and substance abuse among girls. The effort will assess and develop gender-specific programming and services at the Training School.[14]

Juveniles Tried as Adults

◆ When a juvenile has committed a heinous and/or premeditated felony offense or has a history of felony offenses, the Attorney General may request that the Family Court Judge waive jurisdiction so that the juvenile may be tried as an adult in Superior Court. Waiver is mandatory for juveniles age 17 or older who are charged with murder, first degree sexual assault or assault with intent to commit murder.[15]

◆ A juvenile may also be "certified" allowing a court to sentence the juvenile to age 21 or beyond if there is otherwise an insufficient period of time in which to accomplish rehabilitation. While the child is still a minor the sentence is served at the Training School; upon reaching the age of majority the youth is transferred to an adult facility.[16]

◆ In 2002, the Attorney General's Office filed 21 motions to waive jurisdiction to try juveniles as adults. Six of these were mandatory waivers. Two motions to waive were withdrawn, one was dismissed and eight juveniles were waived out of Family Court to adult court. In January 2002, there were 10 waiver motions pending before the Family Court.[17]

References for Indicator

[1] *Best Practices of Youth Violence Prevention: A Sourcebook for Community Action* (June 2002). Atlanta, GA: Centers for Disease Control and Prevention.

[2] *Facts About Youth Violence* (Fact Sheet, October 2002). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

[3,4] *2002 Juvenile Offense Report* (2003). Providence, RI: Rhode Island Family Court.

[5] Rhode Island Family and Juvenile Drug Court, *Newsletter*, Issue 1: Winter 2000.

[6] Pirolli, R. (2001). *Juvenile Hearing Board 2000 Year-End Report*. Providence, RI: Rhode Island Family Court.

[7] Pirolli, R. (2003). *2002 Juvenile Hearing Board Year-End Report Summary* (2003). Providence, RI: Rhode Island Family Court.

[8] Brown, D. et al (2002). *Barriers and Promising Approaches to Workforce and Youth Development for Young Offenders*. Baltimore, MD: The Annie E. Casey Foundation.

[10] Mendel, R. (2001). *Less Cost More Safety: Guiding Lights for Reform in Juvenile Justice*. Washington, DC: The America Youth Policy Forum.

[11] Snyder, R. (November 2002). *Juvenile Arrests 2000*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

[12,13] *Justice by Gender* (May 2001). Washington, DC: American Bar Association and National Bar Association.

[14] Benedict, A. (November 2001). *Gender-Specific Programming for Girls and Young Women Along Rhode Island's Continuum of Care*. Cranston, RI: CORE Associates.

[15,16] R.I. Gen. Laws sections 14-1-7; 14-1-7.1;14-1-7.2; 14-1-7.3.

[17] Rhode Island Office of the Attorney General, 2002.

Juveniles at the Training School

DEFINITION

Juveniles at the training school is the number of juveniles up to age 21 who were in the care and custody of the Rhode Island Training School at any time during the 2001 calendar year. The total includes youth who spent time at the Training School and/or in other community placements while in the care and custody of the Training School.

SIGNIFICANCE

Juvenile detention facilities must balance public safety with the need for treatment and rehabilitation of young offenders.[1] A combination of persistent school problems, family issues, drug use, and/or unmet mental health and special education needs are associated with risk for involvement with the juvenile justice system. Youth who have been violently victimized are more likely to become violent offenders.[2]

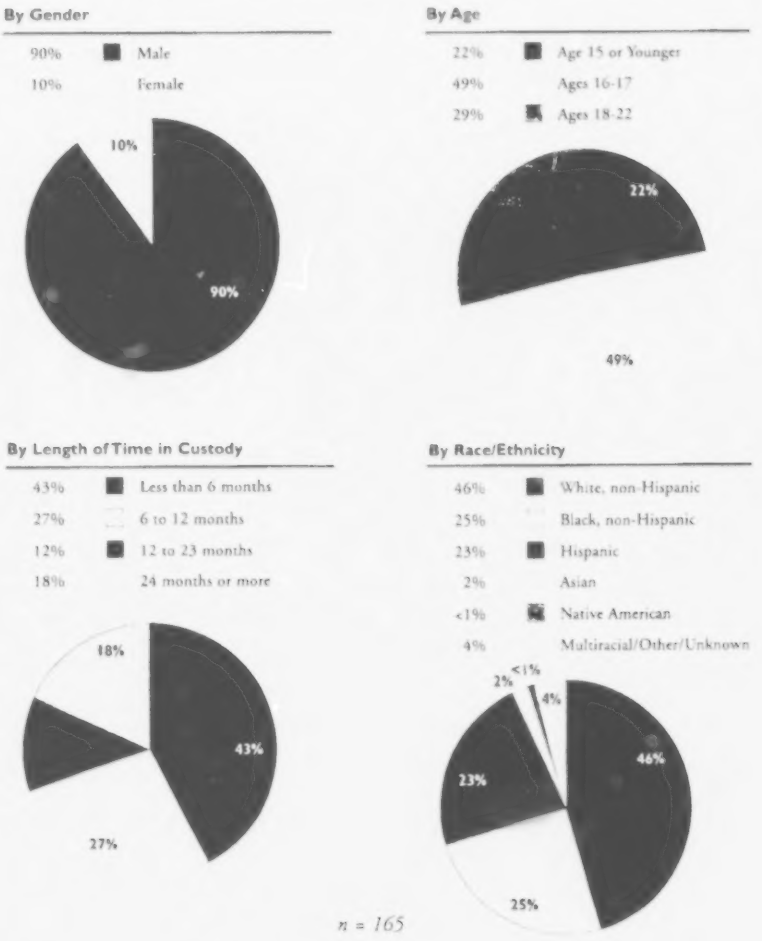
Nationwide, only a fraction of incarcerated youth are violent and dangerous. Most are incarcerated for drug and property offenses that could be addressed through diversion programs. Black youth are incarcerated at five times the rate of White youth. Community placements can help address the large racial disparity among incarcerated youth.[3,4,5]

Research indicates that alternatives to incarcerating youth are both more successful in preventing recidivism and are more cost-effective. Successful efforts use comprehensive community-based strategies that identify risks for youth; focus on prevention, diversion and rehabilitation; and address reintegration into the community.[6] A graduated system of sanctions, treatment and step-down programs can minimize recidivism.[7] In general, for delinquent but non-dangerous youth, sanctions such as community service and restitution or diversion to drug court and substance abuse treatment are more effective than incarceration in reducing reoffending, particularly if integrated into comprehensive programming, counseling and supervision.[8]

The Department of Children Youth and Families operates the Rhode Island Training School for Youth, the state's residential detention facility for adjudicated youth and youth awaiting trial. There were a total of 1,061 youth in the care and custody of the Training School at some point during calendar year 2002. Of these, 18% were female.[9]

As of December 31, 2002, there were 202 youth on the grounds at the Training School, which is 18 more than its capacity. Of these, 43 were unadjudicated (i.e., awaiting trial). An additional 121 youth were within the care and custody of the Training School but were in temporary home or community placements. Three additional youth were classified as runaways.[10]

Juveniles in the Care and Custody of the Rhode Island Training School for Youth, December 31, 2002



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2002. Data are for adjudicated youth only and include youth in community placements.

Risk Factors for Involvement in the Juvenile Justice System

School Failure

◆ A survey of educational records of Training School youth confirms significant academic difficulty. Based on a random review of 86 records on December 1, 2002, 64% (55) had no records available or no records indicative of grades for the past two years. Of the 25 students who had any school records for the previous two years, 13 (52%) had failing grades and 12 (48%) had passing grades.[11]

◆ During 2002, the average age of students at the Training School was 17. Their average self-reported grade placement was 9th grade and their average reading and math grade level was 7th grade.[12]

Unmet Needs for Special Education, Mental Health, or Substance Abuse Services

◆ The cause of delinquent behavior may be directly related to a child's undetected and/or inadequately treated disability, particularly addictive and mental health disorders.[13,14] At the Rhode Island Training School on December 1, 2002, 41% of adjudicated and unadjudicated students were receiving special education services, almost twice the rate of students receiving special education services in Rhode Island public schools in 2002. Most (83%) of Training School students receiving special education services were receiving such services due to behavior disorders and 17% due to learning disabilities.[15,16]

◆ On December 1, 2002, 12% of students at the Training School were receiving psychiatric care and 55% were receiving substance abuse treatment.[17]

◆ Appropriate special education and mental health services are critical to both prevent delinquency and assist in rehabilitation. School failure, unexcused absences, chronic disciplinary problems and grade retention may be associated with a disabling condition that has not been detected.[18]

History of Child Abuse or Neglect

◆ Thirty-seven percent of the adjudicated youth within the care and custody of the Training School on December 31, 2002 (including community placements) had at some point in their childhood been victims in an indicated incident of abuse or neglect.[19]

Prevention of Recidivism Among Delinquent Youth

◆ On December 31, 2002, 67% of the 326 youth in the care and custody of the Training School had been admitted to the Training School at least twice and 19% had been admitted to the Training School at least four times.[20]

◆ Research indicates that early identification and treatment of youth at risk for chronic delinquency and immediate, intensive intervention involving the youth and his or her family in counseling, all-day academic programming and substance abuse treatment or counseling are effective in reducing chronic delinquency.[21]

◆ For serious, repeat, and violent juvenile offenders, the quality of rehabilitative services is critical, because most will return to the community. A successful model of rehabilitation for serious and violent juveniles includes intensive academic and physical work, earning "credit" through behavior to hasten release, trained staff and small staff/inmate ratios and groups, and a heavy focus on transition planning and aftercare services.[22]

References

[1,3,5,8] Puritz, P. et al. (1998). *Beyond the Walls: Improving Conditions of Confinement for Youth in Custody.* Washington, DC: American Bar Association Juvenile Justice Centers and U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[2] Shaffer, J. et al. (December 2002). *Violent Victimization as a Risk Factor for Violent Offending Among Juveniles.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[4,6,7] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1998). Washington, DC: U.S Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[9] Devine, P. et al. (December 1998). *Disproportionate Minority Confinement: Lessons Learned From Five States.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[10] *Minorities in the Juvenile Justice System, 1999 National Report Series* (December 1999). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[11,12,20] Mendel, R. (2001). *Less Cost, More Safety: Guiding Lights for Reform in Juvenile Justice.* Washington, DC: American Youth Policy Forum.

[13,14,15,16] Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2002.

[17,18,19] Rhode Island Training School for Youth, 2002.

[21] Teplin, L. (January 2001). *Assessing Alcohol, Drug, and Mental Disorders in Juvenile Detainees. OJDP Fact Sheet.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[22] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 2002.

84/85 BEST COPY AVAILABLE

Children of Incarcerated Parents

DEFINITION

Children of incarcerated parents is the number of children with a parent in prison per 1,000 children under age 18. The data are reported by the place of the parent's last residence before entering prison.

SIGNIFICANCE

Between 1991 and 1999 in the U.S., the number of children with imprisoned fathers increased 58% and the number of children with imprisoned mothers increased 98%.[1]

As a result of parental incarceration, and the crimes and arrests that precede it, most children experience disruption in their homes, a series of temporary caregivers or placement in foster care, financial hardship, and lack of contact with their parents.[2] Children of incarcerated parents are at greater risk for many negative behaviors including poor academic achievement, substance abuse, and criminal behavior and incarceration.[3,4] Most children with incarcerated parents live in poverty before, during, and after their parents' incarceration and many have been exposed to violent or traumatic experiences.[5,6]

Despite the large and increasing numbers of incarcerated parents, the children they leave behind remain a hidden population with little attention paid to their special needs. The corrections system does not formally recognize these children. Their care arrangements are often handled informally by family members, so they rarely come to the attention of a child welfare agency. While the children may experience problems at school or in other areas of their lives, these problems are often not recognized as being related to the incarceration of a parent.[7,8]

During the past twenty years, there has been a steady increase and change in the make-up of the prison population, due partly to stricter sentencing guidelines and mandatory sentences, particularly for drug-related offenses.[9] One in three mothers in state prison committed drug-related crimes. Mothers are more likely than fathers to report drug use in the month prior to their arrest.[10]

Seventy percent of imprisoned parents in the U.S. do not have a high school diploma. More than one-quarter of fathers and half of mothers were unemployed in the month before their arrests.[11] Upon release from prison, a successful transition to the community often requires ongoing substance abuse or mental health services, adequate housing and assistance entering the job market.[12]

Incarcerated Parents in Rhode Island

◆ Of the 209 women in Rhode Island who were at the Rhode Island Department of Corrections (RIDOC) on December 31, 2002, 76% reported they have children. Of the 3,176 incarcerated men, 52% reported they have children.

◆ Of the 126 women with children who were serving a sentence at the RIDOC on December 31, 2002, 60% were serving a sentence for a nonviolent offense and 17% for a drug offense. Another 17% had committed violent offenses and 6% were serving sentences for other reasons. Of the 1,336 men with children serving sentences, 22% were serving sentences for nonviolent offenses, 22% for drug offenses, 35% for violent offenses and 20% for breaking and entering, sex offenses or other/unknown offenses.

◆ Of the 1,779 parents incarcerated in 2002 in Rhode Island, 49% were White, 29% were Black and 21% were Hispanic.

Source: Rhode Island Department of Corrections, December 2002.

Incarcerated Parents and Their Children in the United States

◆ Children of incarcerated fathers are three times more likely to be in the care of their other parent (the mother) than children of incarcerated mothers. The increasing incarceration of women is particularly disruptive for children, who are likely to lose their primary caretaker when a mother is incarcerated.[13,14]

◆ Male offenders facing sentencing are more likely to be employed outside the home than female offenders, and employment history is often considered in sentencing. Female offenders, in contrast, are more likely to have primary parenting responsibilities, yet these responsibilities and the related well-being of children are rarely considered in sentencing decisions.[15]

Table 20.

Children of Incarcerated Parents

Children of Incarcerated Parents, Rhode Island, 2002

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2000 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	2	3	4,745	0.6
Bristol	8	12	4,399	2.7
Burrillville	12	23	4,043	5.7
Central Falls	80	171	5,531	30.9
Charlestown	3	5	1,712	2.9
Coventry	29	66	8,389	7.9
Cranston	90	186	17,098	10.9
Cumberland	16	29	7,690	3.8
East Greenwich	5	13	3,564	3.6
East Providence	53	119	10,546	11.3
Exeter	9	22	1,589	13.8
Foster	1	3	1,105	2.7
Glocester	5	9	2,664	3.4
Hopkinton	3	4	2,011	2.0
Jamestown	2	3	1,238	2.4
Johnston	35	72	5,906	12.2
Lincoln	11	27	5,157	5.2
Little Compton	0	0	780	0.0
Middletown	7	16	4,328	3.7
Narragansett	13	37	2,833	13.1
New Shoreham	1	3	185	16.2
Newport	62	151	5,199	29.0
North Kingstown	16	30	6,848	4.4
North Providence	30	51	5,936	8.6
North Smithfield	3	8	2,379	3.4
Pawtucket	154	316	18,151	17.4
Portsmouth	4	10	4,329	2.3
Providence	651	1,483	45,277	32.8
Richmond	3	4	2,014	2.0
Scituate	3	5	2,635	1.9
Smithfield	6	12	4,019	3.0
South Kingstown	14	28	6,284	4.5
Tiverton	5	6	3,367	1.8
Warren	11	24	2,454	9.8
Warwick	60	113	18,780	6.0
West Greenwich	3	5	1,444	3.5
West Warwick	47	109	6,632	16.4
Westerly	23	39	5,406	7.2
Woonsocket	101	276	11,155	24.7
Unknown Residence	*198*	*408*	*NA*	*NA*
Core Cities	*1,095*	*2,506*	*91,945*	*27.3*
Remainder of State	*684*	*1,395*	*155,877*	*8.9*
Rhode Island	*1,779*	*3,901*	*247,822*	*15.7*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Corrections based on self-reports from prisoners at the Adult Correctional Institution in Cranston, Rhode Island as of December 31, 2002.

*Data on the number of children are self-reported by the incarcerated parents and may include some children over age 18. Nationally and in Rhode Island, much of the existing research has relied upon self-reporting by incarcerated parents or caregivers.

References for Indicator

[illegible] Mumola, C. (August 2000). *Incarcerated Parents and Their Children.* Washington, DC: Bureau of Justice Statistics, US Department of Justice.

[illegible] Beatty, C. (1997). *Parents in Prison: Children in Crisis: An Issue Brief.* Washington, DC: Child Welfare League of America.

[illegible] Krisberg, B. et al (October 2001). "The Plight of Children Whose Parents Are in Prison" in *NCCD Focus.* Washington, DC: National Council on Crime and Delinquency.

[illegible] Seymour, C. (1998). "Children with Parents in Prison: Child Welfare Policy, Program, and Practice Issues" *Child Welfare*, Vol. 77, No.5, (September/October 1998). Washington, DC: Child Welfare League of America.

[illegible] Seymour, C. B. and Wright, L. E. (2000). *Working with Children and Families Separated by Incarceration: A Handbook for Child Welfare Agencies.* Washington, DC: CWLA Press.

Children Witnessing Domestic Violence

DEFINITION

Children witnessing domestic violence is the percentage of reported domestic violence incidents in which children under age 18 were present in the home. The data are based on police reports of domestic violence in 2001. Domestic violence is the use of physical force, or threat of force, against a current or former partner in an intimate relationship, resulting in fear and emotional and/or physical suffering.

SIGNIFICANCE

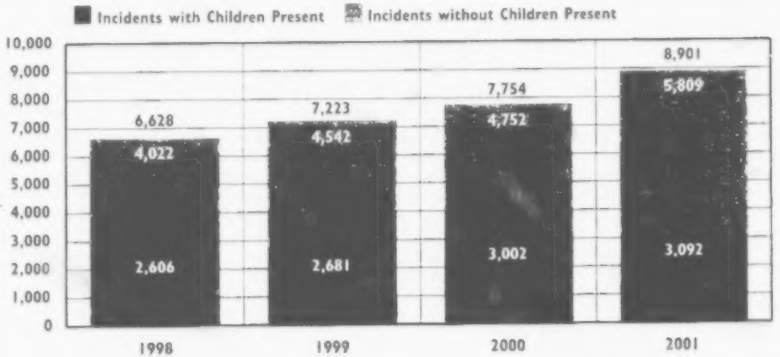
National research indicates that millions of children are exposed to domestic violence each year.[1] In Rhode Island in 2001, police reports indicate that children were present in 35% of domestic violence incidents reported.[2] National surveys of mothers indicate that 80% to 90% of children in homes where there is domestic violence are aware of the abuse.[3]

Children are exposed to domestic violence in several ways. They may witness or hear violent events, become directly involved by trying to intervene, or experience the aftermath of violence by seeing their mother's emotional and physical injuries or damage done to their homes.[4] Children who are exposed to domestic violence are much more likely to be victims of child abuse and neglect.[5] The greater the intensity of the violence against an adult partner, the more likely it is that children are abused as well.[6]

Exposure to violence in the home impairs cognitive, academic and social functioning.[7] Infants may fail to thrive and may not develop attachments to caregivers. Preschool and school-age children who witness domestic violence are more likely to be aggressive and to have behavior problems. They are more prone to depression, anxiety, fear, phobias, sleep disruption, and low self-esteem. Although many children experience these negative effects as a result of exposure to domestic violence, some children emerge from the experience relatively unscathed. A child's age and temperament, the severity and frequency of the violence, and the availability of adults who can emotionally protect or sustain the child greatly affect the child's response.[9]

The effects of exposure to domestic violence can last into adulthood. For males, growing up in a violent home is the strongest predictor of becoming a batterer in the teen and adult years. Both men and women who grow up in violent homes are at increased risk for depression and other trauma-related symptoms.[10]

Domestic Violence Incidents, Rhode Island 1998-2001



◆ The number of domestic violence incidents reported to Rhode Island police increased from 6,628 in 1998 to 8,901 in 2001. The number of reported incidents with children present increased from 2,606 in 1998 to 3,092 in 2001.

Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit, 1998-2001. Includes domestic violence reports from local police and Rhode Island State Police.

Rhode Island's Response to Domestic Violence

◆ Rhode Island's statewide network of six shelters and advocacy programs provides services to victims of domestic violence, including shelter, advocacy, counseling and education. During 2002, 455 women and 359 children spent time in a domestic violence shelter. Rhode Island's domestic violence agencies provided services to 921 children including therapy, individual counseling, expressive arts therapy, and child care. The shelters also provide school-based domestic violence prevention programs.[11]

◆ During Rhode Island's 2002 legislative session, a number of bills were passed that strengthen legal protections for victims of domestic violence. These provisions make stalking a felony on the first offense; allow bail and probation violators to be held without bail until the next court session; prohibit discrimination in housing against victims of domestic violence; and strengthen requirements that domestic violence be taken into account in structuring child visitation.[12]

Children Witnessing Domestic Violence

Children and Domestic Violence in Rhode Island

◆ Rhode Island police officers use special reporting forms to document children's exposure to domestic violence. The attending officer may check any combination of three boxes: Were children present during the incident? Did children witness the incident? Did children hear the incident?[13]

◆ In 2001, police officers reported that in 2,288 incidents the children saw their parent being abused and in 2,553 incidents the children heard (but did not see) their parent being abused.[14]

◆ Table 21 underrepresents the number of incidents of domestic violence in which a child was present because police reports are not fully completed in all cases. Additionally, many cases of domestic violence are never reported to police.

◆ Table 21 underestimates the total number of children who experienced domestic violence in their homes, because more than one child may be present at an incident.

Table 21.

Domestic Violence Incidents with Children Present, Rhode Island, 2001

CITY/TOWN	TOTAL NUMBER OF DOMESTIC VIOLENCE INCIDENT REPORTS	TOTAL NUMBER OF INCIDENTS IN WHICH A CHILD WAS PRESENT	% OF INCIDENTS WITH CHILDREN PRESENT
Barrington	57	19	33%
Bristol	203	58	29%
Burrillville	103	51	50%
Central Falls	159	72	45%
Charlestown	44	16	36%
Coventry	261	95	36%
Cranston	436	147	34%
Cumberland	124	38	31%
East Greenwich	48	15	31%
East Providence	256	103	40%
Exeter	NA	NA	NA
Foster	19	5	26%
Glocester	94	25	27%
Hopkinton	47	22	47%
Jamestown	10	2	20%
Johnston	420	133	32%
Lincoln	81	31	38%
Little Compton	17	5	29%
Middletown	163	59	36%
Narragansett	124	45	36%
Newport	446	152	34%
New Shoreham	8	1	13%
North Kingstown	293	112	38%
North Providence	299	100	33%
North Smithfield	74	25	34%
Pawtucket	845	302	36%
Portsmouth	164	54	33%
Providence	1,733	564	33%
Richmond	17	4	24%
Scituate	35	19	54%
Smithfield	116	38	33%
South Kingstown	138	42	30%
Tiverton	196	72	37%
Warren	259	71	27%
Warwick	430	171	40%
Westerly	170	63	37%
West Greenwich	18	6	33%
West Warwick	244	95	39%
Woonsocket	622	218	35%
Rhode Island State Police	*128*	*42*	*33%*
Core Cities	*4,049*	*1,403*	*35%*
Remainder of State	*4,724*	*1,647*	*35%*
Rhode Island	*8,901*	*3,092*	*35%*

Source of Data for Table/Methodology

The number of domestic violence incident reports and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received by the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 2001 and December 31, 2001.

Reports of domestic violence in Exeter are included in the Rhode Island State Police numbers.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] "Domestic Violence and Children: Analysis and Recommendations" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2,14] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received from police departments between January 1, 2001 and December 31, 2001.

[3,5,10] *Domestic Violence and Its Impact on Children* (Fact Sheet)(2000). Washington, DC: Children's Defense Fund.

[4,7,8] Fantuzzo, J. and Mohr, W. (1999), "Prevalence and Effects of Child Exposure to Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[6] *The Co-occurrence of Intimate Partner Violence Against Mothers and Abuse of Children* (1999). Atlanta, GA: Centers for Disease Control and Prevention.

[9] McAlister Groves, B. "Mental Health Services for Children Who Witness Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[11] The Rhode Island Coalition Against Domestic Violence. Data for period from January 1, 2002 to December 31, 2002.

[12] "Top Priority Bills Passed This Year" in *Voices against Violence* (Summer/Fall 2002). Vol. 11, No.2. Providence, RI: Rhode Island Coalition Against Domestic Violence.

[13] Rhode Island Domestic Violence and Sexual Assault Reporting Form.

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated investigations of child abuse and neglect per 1,000 children. Indicated investigation means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated investigation can involve more than one child and multiple allegations (claims) of different forms of abuse. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes emotional, educational and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in poor school performance, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional and mental health problems, promiscuity, and teenage pregnancy.[2,3,4,5]

Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[6,7]

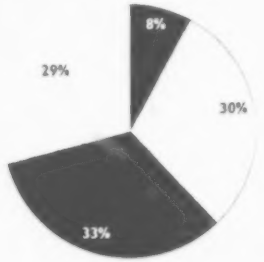
Responding to reports of child abuse and neglect and ensuring child safety in crisis situations are important functions of child protection systems. However, maintaining the capacity to focus on prevention is equally critical and frequently more cost-effective. Currently in Rhode Island, a disproportionate share of the budget of the Department of Children, Youth and Families (DCYF) continues to be spent on high-end costs such as psychiatric hospitalization, juvenile corrections, and residential treatment.[8,9,10]

In 2002 in Rhode Island, there were 2,209 indicated cases of child abuse and neglect involving 2,987 children, a rate of 7.4 cases per 1,000 children.[11] During 2001, there were 29 children hospitalized with the diagnosis of child abuse or neglect.[12]

Child Abuse and Neglect, Rhode Island, 2002

By Age of Victim

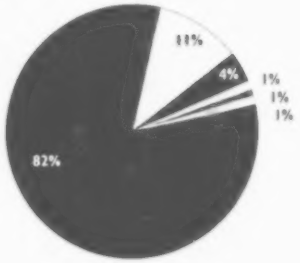
8%	Under Age 1
30%	Ages 1 to 5
33%	Ages 6 to 11
29%	Ages 12 and Older



*(n=2,987)**

By Relationship of Victim to Perpetrator

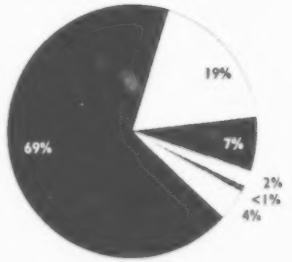
82%	Parents
11%	Relatives/Household Members
4%	Child Care Providers
1%	Foster Parents
1%	Residential Facility Staff
1%	Other or Unknown



*(n=3,798)****

By Type of Abuse

69%	Neglect
19%	Physical Abuse
7%	Sexual Abuse
2%	Medical Neglect
<1%	Emotional Abuse
4%	Other



*(n=3,651)***

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2002. Numbers may not add to 100 due to rounding.

** These data reflect an unduplicated count of child victims. The number of victims is higher than the number of indicated investigations. One indicated investigation can involve more than one child victim.*

***This number is greater than the unduplicated count of child victims because children often experience more than one maltreatment event and/or more than one type of abuse. Within each type of abuse, the number of child victims is unduplicated.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1995-2002

YEAR	TOTAL NUMBER UNDUPLICATED CHILD MALTREATMENT REPORTS	NUMBER OF COMPLETED INVESTIGATIONS**	NUMBER OF INDICATED CASES
1995	13,841	8,553	2,781
1996	13,098	8,398	2,541
1997	12,437	8,485	2,577
1998	12,674	8,463	2,459
1999	13,519	7,882	2,628
2000	13,580	7,635	2,234
2001	13,804	7,479	2,261
2002	14,545	7,254	2,209

◆ In 2002, DCYF received 14,545 calls to the Rhode Island Child Abuse Hotline (1-800-RI-CHILD); completed 7,254 investigations of child abuse reports; and determined that there were 2,209 indicated cases in which credible evidence existed that child abuse and/or neglect occurred.

** One investigation can be generated by multiple hotline calls.*

Source: All data are from the Rhode Island Department of Children, Youth and Families, 1995-2002.

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1993	3	1998	3
1994	5	1999	3
1995	5	2000	3
1996	4	2001	5
1997	2	2002	1
Total 1993-1997	*19*	*Total 1998-2001*	*15*

◆ Between 1993 and 2002, 34 children died as a result of injuries due to abuse by a parent or caretaker.

**Based on R.I. Department of Children Youth and Families determination of death due to child abuse or neglect by a parent or caretaker.*

Family and Community Centered Practice

◆ The objectives of the Adoption and Safe Families Act of 1997 include the safety, stability and well-being of children. Spurred by these goals, as well as the Act's requirements for adherence to strict timelines, national research has focused on developing new approaches for child welfare systems. Family-centered practice is one such strategy. It seeks to use the strengths of nuclear and extended families and communities in order to be culturally competent and to promote strong networks of both formal and informal community-based resources.[13]

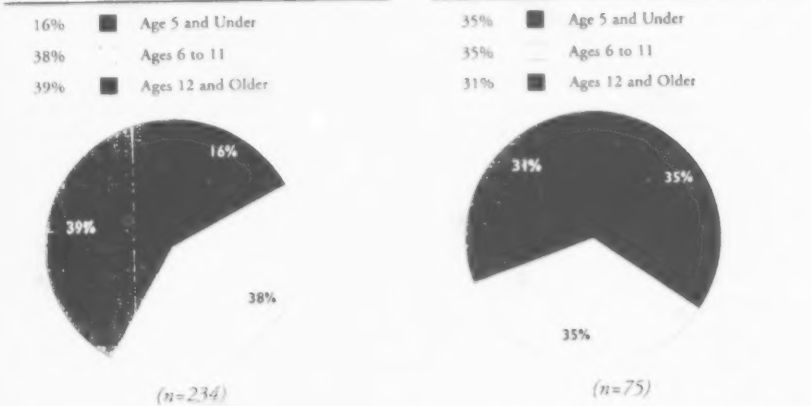
◆ The Family-Centered Practice Initiative is a Rhode Island demonstration project initiated in 2001 that seeks to change DCYF practices in order to better involve families in designing strategies for achieving desired family outcomes. Core practice strategies include full-disclosure, strength-based assessments, family-driven case plans, concurrent planning (i.e., simultaneous planning for reunification with the family and for alternative permanent placement) and the use of professional teams.[14]

◆ Recognizing that change within DCYF is not sufficient, the initiative is designed to involve communities and community providers in this new approach and to measure concrete outcome changes achieved for children.[15]

◆ As part of bringing the demonstration project to scale throughout the state, in 2003 the initiative will begin providing comprehensive training in family-centered practice to both DCYF staff and community service providers. The initiative also aims to implement neighborhood-based strategies to recruit and train community partners, and resource families to provide family-to-family support within the community.[16]

Child Abuse and Neglect

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2002



◆ In Rhode Island in 2002, there were 309 indicated allegations (confirmed claims) of sexual abuse. Some children were victims of sexual abuse more than once. Multiple allegations may be involved in each indicated investigation. An indicated allegation of abuse is defined as one in which credible evidence was found indicating sexual abuse.

◆ In 76% (234) of the 309 indicated allegations of sexual abuse the victim was a female. More than half of the victims (55% of girls and 70% of boys) were under age 12.

◆ The most frequent perpetrators of sexual abuse were relative caretakers (20%), other household caretakers (17%), step-parents (16%), birth parents (15%) and baby sitters/caretakers (13%). There were two instances of sexual abuse by residential facility staff and two instances of sexual abuse by a day care provider.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2002.

Maltreatment of Children with Disabilities

◆ Studies indicate that children with disabilities are between two and three times more likely to be maltreated than children without disabilities. Children with emotional and behavioral disorders are at greatest risk of abuse and neglect.[17]

◆ A number of factors can contribute to increased rates of abuse and neglect of children with disabilities. Family stress, isolation, lack of supports and training are contributing factors.[18]

◆ Institutionalization and care provided by caregivers who may be encouraged to remain emotionally detached can contribute to increased neglect and abuse rates. Societal attitudes and myths may lead to devaluing and/or segregating children with disabilities and may increase abuse rates.[19]

◆ The child's physical and emotional reliance on caregivers and lack of understanding of appropriate personal boundaries may increase vulnerability.[20]

◆ Preventing abuse of children with disabilities requires a combination of strategies aimed at changing societal attitudes about children with disabilities; providing families with parenting education, respite, and access to a variety of supports and services; increasing the knowledge and safety skills of children with disabilities; and effective policies and procedures in settings involving non-familial caregivers, including supervision, training and adequate staff/client ratios.[21]

Table 22.

Indicated Cases of Child Abuse and Neglect, Rhode Island, 2002

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	2002 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	5,211	11	2.1
Bristol	6,294	27	4.3
Burrillville	4,646	21	4.5
Central Falls	6,443	63	9.8
Charlestown	1,952	11	5.6
Coventry	9,438	58	6.1
Cranston	19,854	120	6.0
Cumberland	8,595	41	4.8
East Greenwich	3,861	10	2.6
East Providence	12,060	78	6.5
Exeter	1,790	5	2.8
Foster	1,234	6	4.9
Glocester	2,998	10	3.3
Hopkinton	2,255	10	4.4
Jamestown	1,354	7	5.2
Johnston	6,729	40	5.9
Lincoln	5,720	25	4.4
Little Compton	874	4	4.6
Middletown	4,757	27	5.7
Narragansett	3,897	13	3.3
New Shoreham	203	0	0.0
Newport	7,046	83	11.8
North Kingstown	7,561	46	6.1
North Providence	6,854	47	6.9
North Smithfield	2,674	10	3.7
Pawtucket	20,870	196	9.4
Portsmouth	4,726	12	2.5
Providence	62,125	600	9.7
Richmond	2,221	11	5.0
Scituate	2,944	9	3.1
Smithfield	6,112	8	1.3
South Kingstown	10,393	34	3.3
Tiverton	3,806	22	5.8
Warren	2,809	21	7.5
Warwick	21,330	142	6.7
West Greenwich	1,606	6	3.7
West Warwick	7,746	91	11.7
Westerly	6,094	38	6.2
Woonsocket	12,792	188	14.7
Out of State/Unknown	*NA*	*58*	*NA*
Core Cities	*117,022*	*1,221*	*10.4*
Remainder of State	*182,852*	*988*	*5.4*
Rhode Island	*299,874*	*2,209*	*7.4*

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated investigations) for the period January 1, 2002 to December 31, 2002. An indicated investigation is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated investigation can involve more than one child and multiple allegations.

The denominator is the number of children under the age of 21 according to the 2000 U.S. Census of Population.

References for Indicator

[1,2,3] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[4,7] "Protecting Children from Abuse and Neglect" in *The Future of Children*, Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[5] English, D. (1998). "The Extent and Consequences of Child Maltreatment" in *The Future of Children*, Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: The David and Lucile Packard Foundation.

[6] Chalk, R. et al. (May, 2002). *The Multiple Dimensions of Child Abuse and Neglect: New Insights into an Old Problem*. Washington, DC: Child Trends.

[8] D'Ambra, L. (September 2001). *DCYF System of Care Task Force Report of the Current Reality Subcommittee*. Providence, RI: Office of the Child Advocate.

[9] *A Review of the Rhode Island Department of Children, Youth and Families* (January 2001). Providence, RI: Rhode Island Public Expenditure Council.

[10] *Towards an Organized System of Care for Rhode Island's Children, Youth and Families*. (January 2003). The Report of the Rhode Island System of Care Task Force.

[11] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System, 2002.

[12] Rhode Island Department of Health, Hospital Discharge Database, FY 2001.

[13] *Rethinking Child Welfare Practice under the Adoption and Safe Families Act of 1997* (November 2000). Washington, DC: U.S. Department of Health and Human Services.

[14,15,16] *Family Centered Practice: A New Perspective on Permanency for Rhode Island's Child Welfare System*. Material developed in collaboration with: The Rhode Island Department of Children, Youth and Families; The Child Welfare Institute at Rhode Island College; The National Resource Center for Foster Care and Permanency Planning; The National Child Welfare Resource Center for Family-Centered Practice.

[17,18,19,20,21] *The Risk and Prevention of Maltreatment of Children with Disabilities* (February 2001). Washington, DC: The Administration for Children and Families, National Clearinghouse on Child Abuse and Neglect.

Children in Out-of-Home Placement

DEFINITION

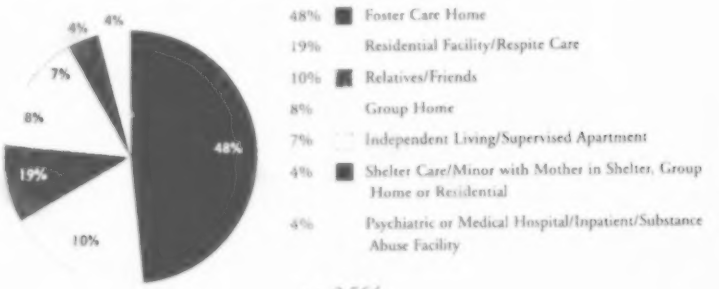
Children in out-of-home placement is the number of children who have been removed from their families and are in the care of the Rhode Island Department of Children, Youth and Families (DCYF) while awaiting permanent placement. Out-of-home placements include foster homes, placement with a relative or friend, group home, shelter care, residential treatment, and medical facility. Permanent placement includes reunification with the family, adoption or guardianship.

SIGNIFICANCE

Children need stability, permanency and safety in order to develop and flourish. Removal from the home may be necessary for the child's safety and well-being; however, it is disruptive and can be traumatic for both the child and the family.[1] Children who have been abused or neglected are particularly vulnerable and in need of a safe, stable and permanent environment which provides for their well-being. Yet children in out-of-home care frequently remain in temporary placements for extended periods of time, experience multiple placements, lose contact with family members, friends and neighborhoods, and may experience recurrence of abuse.[2] Older children may linger in care until adulthood.

Long-term stays in temporary out-of-home placement can negatively affect children, causing emotional, behavioral or educational problems that adversely affect their future well-being and self-sufficiency.[3] Children in out-of-home care suffer more frequent and more serious medical, developmental, and mental health problems than nearly any other group of children. Nationally, systemic and service barriers prevent many children in state custody from receiving adequate care. Effective strategies to promote the optimal development of children in out-of-home placement include: assessment on system entry; a comprehensive system of care to address identified health (physical, mental, emotional, behavioral) and educational needs immediately; family involvement; training and education for caregivers; coordinated services and funding strategies; and using a managed care model that addresses the complex needs of children in the child welfare system.[4,5]

Children in Out-of Home Placement, December 2002



n = 2,564

◆ As of December 31, 2002, there were 2,564 children under age 21 in the care of DCYF who were in out-of-home placement.

◆ The total caseload of DCYF on December 31, 2002 was 8,327 including 2,929 children living in their home (with a parent, guardian or step-parent) under DCYF supervision; 2,449 children receiving subsidized adoption supports; 203 children/youth in detention at the Training School or in prison; 37 children in out-of-state placement/placement with another agency; and 15 children in Job Corps or other placement. An additional 130 children and youth in the care of DCYF were classified as unauthorized absence/runaways.

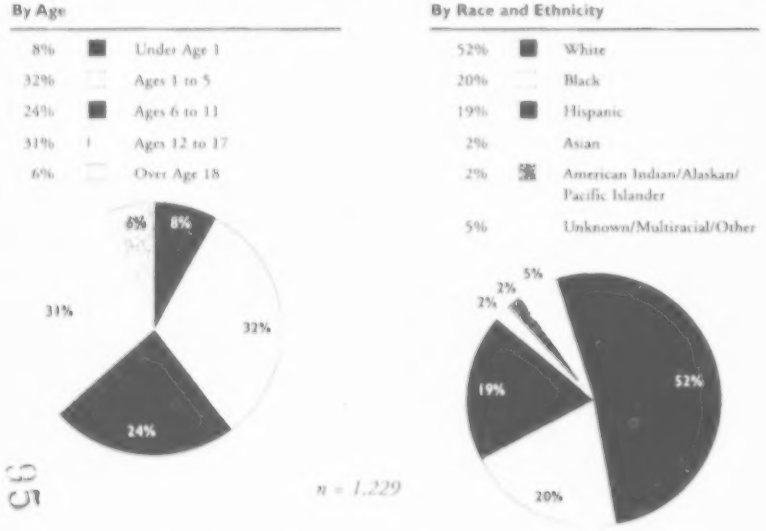
Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2002.

Night-to-Night Placements

◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting longer-term placements. Night-to-night placements are currently the subject of pending litigation between the Department of Children, Youth and Families and the Office of the Child Advocate, which seeks to eliminate such placements.

◆ In 2002, 487 children (an average of 18 children per week) were placed in night-to-night placements. This was a total of 2,322 bed nights, i.e., instances when a night-to-night placement is used by a child and paid for by DCYF.[6]

Children in Foster Care Homes, Rhode Island, 2003



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2003

◆ As of January 2, 2003, there were 1,229 children in foster care homes. Of these, 561 (46%) were in non-relative foster homes, 545 (44%) were in relative foster homes, and 123 (10%) were in the care of private agencies. Four additional children were in respite care. In Rhode Island and nationally there is an ongoing shortage of foster parents.[7,8]

Safety, Permanency and Well-Being

◆ The Adoption and Safe Families Act of 1997 (ASFA) recognizes that the broad goals of child protection systems are child safety, permanency and well-being. Preventing the recurrence of abuse or neglect, ensuring the safety of children in out-of-home placement, and maximizing stability of placements are the paramount concerns which the Act seeks to address.

◆ Of the 1,624 Rhode Island children who were victims of abuse or neglect during the first six months of federal fiscal year 2001 (whether or not they were removed from the home), 11.0% (179) experienced one or more recurrences of abuse or neglect within 6 months, down from 12.6% in 1998.[9]

◆ In FY 2001, 21% (1,710) of children who had been in out-of-home care for less than one year had experienced 3 or more placements, down from 27% in FY 1998. Three or more placements were experienced by 45% of children who had been in care between 12 and 23 months, down from 47% in 1998; 54% of children who had been in care for 24-35 months experienced three or more placements (no change from 1998).[10]

◆ One measure of well-being is the level of educational services and special education supports that children who have special needs are receiving while in DCYF custody. The Educational Surrogate Parent Program at the Office of the Child Advocate advocates for children's special educational needs while in out-of-home care. As of December 2002, the Surrogate Program had 1,028 open cases on children with special educational needs.[11]

References for Indicator

[1] "Protecting Children from Abuse and Neglect" in *The Future of Children*, Vol. 8, No.1 (Spring 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2] *Child Welfare Outcomes 1998, Annual Report* (2000). Washington, DC: U.S. Department of Health and Human Services.

[3] Lovejoy, Anna (October 2000). *A Place to Call Home: State Efforts to Increase Adoptions and Improve Foster Care Placements*. Washington, DC: National Governor's Association Center for Best Practices.

[4] *Health Care Needs of Children in the Foster Care System* (May 2002). Washington, D.C.: Georgetown University Child Development Center.

[5] Knitzer, J. (2001). *Improving the Odds for Healthy Development of Young Children in Foster Care*. New York , NY: National Center for Children in Poverty.

[6,11] Office of the Child Advocate, January 2003.

[7] *Recruiting Foster Parents* (2002). Washington, D.C.: Department of Health and Human Services, Office of Inspector General.

[8] *Retaining Foster Parents* (2002). Washington, D.C.: Department of Health and Human Services, Office of Inspector General.

[9,10] National Child Abuse and Neglect Data System, Detailed Case Data Component, Annual Foster Care Database, January-September, 1998, 1999, 2000, 2001and FY 1998, 1999, 2000, 2001.

Adoption and Permanency

DEFINITION

Adoption and permanency is the percentage of children in out-of-home care who transition to a permanent placement through adoption, reunification or guardianship. Data are for all children who were in out-of-home placement during federal fiscal year 2001.

SIGNIFICANCE

The uncertainty of multiple, prolonged or unstable out-of-home placements has negative effects on children's emotional well-being, identity formation, and sense of belonging, impacting behavior, academic achievement and long term self-sufficiency.[1,2] Youth who age out of care without finding a permanent placement or who spend significant parts of their adolescence in foster care suffer disproportionately from poverty, unemployment, academic failure, incarceration and premature parenting.[3]

One of the goals of the federal Adoption and Safe Families Act of 1997 (ASFA) is to ensure that children exit out-of-home placement to permanent placement, i.e. reunification, adoption or guardianship, as quickly as possible without jeopardizing the child's safety. Effectiveness in achieving permanency must include the interrelated measures of how quickly permanency is achieved, the proportion of children for whom it is achieved, and the lasting success of the permanent placements.[4] In addition, increasing attention is being paid to the long-term personal, social, academic and economic outcomes achieved for children who leave the child welfare system.[5,6,7]

National experience indicates that particular attention must be paid to populations of children for whom permanency may be more difficult to achieve. This includes older children, children with disabilities and minority children.[8,9] Planning for permanency requires a mix of family-centered and legal strategies designed to ensure that children and youth have safe, caring, stable and lifelong families in which to grow up.[10]

In Rhode Island, during federal fiscal year 2001, 29% (1,049) of the 3,615 children in out-of-home placement exited care to a permanent placement.[11]

Percentage of Children in Out-of-Home Care Exiting Care to a Permanent Placement, Rhode Island, FY 2001

Of the 3,615 children in out-of-home placement in FY 2001, twenty-nine percent (1,049) exited care to a permanent placement.

Children Who Exited Foster Care in FY 2001

	All Exits	With Disability	Age 12 or More at Entry
Adoption	14%	12%	N/A
Guardianship	3%	3%	2%
Reunification with Parents	69%	65%	72%
Other	14%	19%	24%
Missing	1%	<1%	2%
Total Number	*1,227*	*242*	*561*

◆ In FY 2001 there were 3,615 children in out-of home placements. Of these, 1,227 children exited care. Of the children who exited care, 1,049 children exited to a permanent placement such as adoption, guardianship or reunification. This was 86% of those exiting care but 29% of those in out-of-home placement.

Source: U.S. Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System (AFCARS) Annual Foster Care Database, FY 2001. Throughout this indicator, fiscal year refers to federal fiscal year, Oct. 1 - Sept 30.

Children Aging Out of Foster Care*

◆ Children who do not exit care promptly may eventually "age out," never having found a permanent placement. In FY 2001, 77 Rhode Island children exited out-of-home placement to emancipation. Of these, 81% were older than age 12 at entry into care.[12]

◆ Successful permanency planning for older children must be individualized to the youth's situation and open to an expanded range of permanency options including adoption (both with and without continued contact with birth parents or other family members), subsidized guardianships, permanent relative placement and planned long-term foster care.[13]

*Foster care refers to all out-of home placements, consistent with language used in federal reports.

Length of Time to Adoption or Reunification, Rhode Island, FY 1998-2001

	Adoption		Reunification	
	1998	2001	1998	2001
Less than 24 months	28%	44%	75%	86%
More than 24 months	63%	55%	6%	11%
Missing data	9%	1%	19%	3%

◆ The percentage of children in the Rhode Island child welfare system who were adopted in less than 24 months increased from 28% in FY 1998 to 44% in FY 2001.

◆ The percentage of children in the Rhode Island child welfare system who were reunified with their family of origin in less than 24 months increased from 75% in FY 1998 to 86% of children in FY 2001.

Source: U.S. Department of Health and Human Services, AFCARS Annual Foster Care Database, FY 1998 and 2001.

Children Re-Entering Foster Care after Prior Episode, FY 1998-2001

Success in reducing the duration in temporary placement must be measured in conjunction with rates of re-entry into the system (i.e., the failure rate of the permanent placement).

◆ In FY 2001, 34% of children in Rhode Island who entered out-of-home placement were re-entering after a prior episode, up from 27% in 1998.[vi]

◆ Research indicates that adoptions are most likely to be successful when agencies provide accurate information about the circumstances of the children to be adopted, assist families with obtaining compensatory education services for the children, and offer flexible, long-term, post-adoptive services.[vii] Specialized support is particularly critical for families adopting children with special needs, and may need to include family and child therapy and respite care.[viii]

Adoptions of Children in DCYF Care, 2002

◆ In calendar year 2002, 254 children in the care of DCYF were adopted in Rhode Island. Of these children, 52% were White, 20% were Black, 14% were Hispanic and 14% were other racial/ethnic groups or unknown.

◆ Of the children adopted, 54% were under age 6, 37% were between age 6 and 11 and 9% were age 12 or older.

◆ As of December 31, 2002, 207 children in the care of DCYF were awaiting adoption. Of these children, 49% were White, 25% were Black, 21% were Hispanic and 5% were other racial/ethnic groups or unknown.

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2002

References

[i] Lowery, A. (October 2000). *A Place to Call Home: State Efforts to Increase Adoptions and Improve Foster Care Placement*. Washington, DC: National Governors Association Center for Best Practices.

[ii] "Preface to Contemporary Issue in Permanency Planning" in *Child Welfare* (March/April 2002). Vol. LXXXI, #2.

[iii] Wertheimer, R. (December 2002). "Youth who 'Age Out' of Foster Care: Troubled Lives, Troubling Prospects" in *Child Trends Research Brief*. Washington, DC: Child Trends.

[iv] *Child Welfare Outcomes 1998: Annual Report* (2000). Washington, DC: U.S. Department of Health and Human Services.

[v] Billing, A. (May 2002). *Children Cared for by Relatives: What Do We Know about Their Well-Being?* Washington, DC: Urban Institute.

[vi] Kaufman, N. (September 2000). "Do We Really Mean Families for All Children? Permanency Planning for Children with Developmental Disabilities" in *Policy Research Brief*. Vol. 1, No. 3. Minneapolis, MN: University of Minnesota.

[vii] Kemp, S. et al. "Beyond Termination: Length of Stay and Predictors of Permanency for Legally Free Children" in *Child Welfare* (January/February 2002). Vol. LXXXI, #1.

[viii] U.S. Department of Health and Human Services, AFCARS Annual Foster Care Database, FY 2001. Missing data in 1998 (25%) and to a lesser extent in 1999 (5%) may be responsible for some of the differential.

[ix] Barth, R. (2000). "What Works in Permanency Planning: Adoption" in *What Works in Child Welfare*. Washington, DC: CWLA Press.

[x] McGlone, K. et al. "Psychological Stress in Adoptive Parents of Special-Needs Children" in *Child Welfare* (March/April 2002). Vol. LXXXI, #3.

Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

Child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 2000, 62% (45,820) of children under age 6 had all parents in the workforce, higher than the U.S. average of 59%.[1]

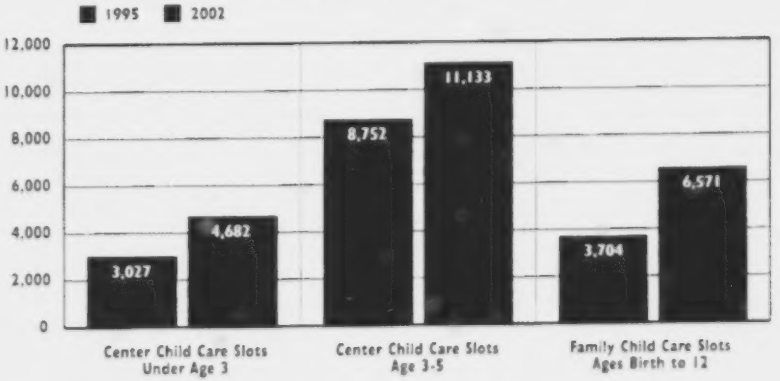
High quality child care provides a safe and nurturing learning environment for infants and young children. Recent brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[2,3,4] High quality child care programs are linked to school readiness. Children from all backgrounds who have received high quality child care score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[5,6]

Low-income children who receive high quality early education score significantly higher on tests of reading and math from the early grades through middle adolescence and are less likely to repeat a grade. They are more interested in learning, and are stronger in reading, math, thinking, problem solving and working with others.[7,8] Low-income children are less likely to be in high quality care arrangements because of the high cost of such care, and because nonstandard work hours (weekends, night shifts, irregular hours) make it difficult to find such care.[9,10,11]

The quality of child care is strongly related to the wages, education, and retention of teachers. Initiatives designed to increase wages and benefits can improve child care workforce education and retention, particularly when professional development and education are linked to pay increases.[12]

In 2002 in Rhode Island, there were 22,386 slots in licensed child care centers or certified family child care homes for children under age six, as compared with 15,483 slots in 1995. In 2002 in Rhode Island, 33 of the 269 licensed child care centers serving children under age 6 were accredited by the National Association for the Education of Young Children and 12 of the 1,071 certified family child care homes were accredited by the National Association for Family Child Care.[13]

Infant and Pre-School Licensed Child Care Capacity, Rhode Island, 1995 and 2002



Source: Options for Working Parents, 1995 and 2002.

The Impact of Child Care on the Economy

◆ The child care sector contributes $38 billion-$41 billion a year to the national economy in direct expenditures and generates over $9 billion a year in tax revenues. It directly employs more workers than public secondary schools. It creates an infrastructure that permits parents to be employed outside the home, generating additional billions of dollars of taxable earnings each year.[14]

◆ Recent research indicates that high quality child care also makes significant long-term contributions to the economy due to improved outcomes for families and children. High quality child care can generate a four to one return on investment due to increased lifetime earnings of both the child and the mother and in decreased public expenditures on special education, remedial education and medical costs.[15]

◆ Responsive caregivers who surround children with language, warmth and chances to learn are the key to good child outcomes.[16] Lower child-staff ratios, smaller group sizes and better-educated teachers provide better quality overall, including more positive caregiving and a more developmentally-appropriate learning environment.[17,18,19]

Table 23.

Child Care for Children Under Age 6, Rhode Island, 2002

CITY/TOWN	# CHILD CARE CENTER SLOTS < AGE 3	# CHILD CARE CENTER SLOTS AGES 3-5	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	TOTAL REGULATED CHILD CARE SLOTS FOR CHILDREN < AGE 6	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	SLOTS PER 100 CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE
Barrington	45	144	29	218	400	55
Bristol	33	94	71	198	463	43
Burrillville	16	78	36	130	422	31
Central Falls	39	137	186	362	537	67
Charlestown	10	19	27	56	175	32
Coventry	107	281	117	505	995	51
Cranston	274	865	370	1,509	1,860	81
Cumberland	57	125	193	375	943	40
East Greenwich	297	483	47	827	287	288
East Providence	220	584	155	959	1,208	79
Exeter	8	45	25	78	195	40
Foster	31	35	8	74	111	67
Glocester	16	66	50	132	273	48
Hopkinton	0	0	21	21	292	7
Jamestown	31	33	6	70	86	81
Johnston	107	353	102	562	726	77
Lincoln	188	236	29	453	584	78
Little Compton	0	0	0	0	54	0
Middletown	149	262	12	423	479	88
Narragansett	41	90	6	137	236	58
New Shoreham	0	0	0	0	28	0
Newport	100	163	22	285	636	45
North Kingstown	141	286	71	498	832	60
North Providence	67	193	145	405	684	59
North Smithfield	0	0	59	59	295	20
Pawtucket	422	617	506	1,545	2,174	71
Portsmouth	80	118	44	242	425	57
Providence	864	2,276	3,361	6,501	4,136	157
Richmond	0	37	51	88	263	33
Scituate	12	47	11	70	298	23
Smithfield	128	207	48	383	413	93
South Kingstown	104	198	78	380	610	62
Tiverton	25	145	53	223	370	60
Warren	25	93	39	157	336	47
Warwick	607	1,373	273	2,253	2,191	103
West Greenwich	133	174	5	312	179	174
West Warwick	76	270	111	457	762	60
Westerly	72	387	0	459	666	69
Woonsocket	157	619	204	980	1,137	86
Core Cities	*1,658*	*4,082*	*4,390*	*10,130*	*9,382*	*108*
Remainder of State	*3,024*	*7,051*	*2,181*	*12,256*	*17,379*	*71*
Rhode Island	*4,682*	*11,133*	*6,571*	*22,386*	*26,761*	*84*

**Family child care home slots are for children birth to 12 years old.*

Source of Data for Table/Methodology

The denominator is the number of children under age 6 with both parents in the workforce, multiplied by 58.4% (the percentage of parents using non-relative care, according to the Census Bureau's Survey of Income and Program Participation, Spring 1997). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots, as of December 31, 2002 (data provided by Options for Working Parents).

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

See Methodology page 125.

References

[1] U.S. Bureau of the Census, Census of Population, 2000.

[2] Shore, R. (1997). *Rethinking the Brain*. New York, NY: Families and Work Institute.

[3] *From Neurons to Neighborhoods: The Science of Early Childhood Development* (2000). Washington, DC: National Academy Press.

[4] *Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness* (2000). New York, NY: Carnegie Corporation of New York and National Center for Children in Poverty.

[5] *The Children of the Cost, Quality, and Outcomes Study Go to School* (June 1999). Chapel Hill, NC: The University of North Carolina at Chapel Hill.

[6] *Vandell, D. Lowe and Wolfe, B. (2000). Child Care Quality: Does It Matter and Does It need to be Improved?* Madison, WI: Institute for Research on Poverty, University of Wisconsin at Madison.

[7] *Early Learning, Later Success: The Abecedarian Study, Executive Summary* (1999). Chapel Hill, NC: Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

[8] Xiang, Z. et. al. (January 2002). *Effects Five Years Later: The Michigan School Readiness Program Evaluation Through Age 10*. Ypsilanti, MI: For the Michigan State Board of Education.

[9] Marshall, N. et. al. (2001). *The Cost and Quality of Full Day, Year-round Early Care and Education in Massachusetts: Preschool Classrooms (Executive Summary)*. Wellesley Centers for Women, Wellesley, MA.

continued on page 126

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 2002.

SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families.[1] Children are eligible for Head Start if their family's income is below 100% of the federal poverty line; the family receives SSI or is enrolled in the Family Independence Program; or the family is using supportive services that are federal TANF benefits, such as transportation vouchers, subsidized child care, or job training. Children in foster care are also Head Start eligible. Up to 10% of the children served by Head Start can be in families that do not meet these eligibility guidelines, especially if the child has a special need.[2,3]

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children. Head Start performance standards require that programs deliver a high-quality early childhood education program; involve parents in program policy and planning; provide at least one nutritional meal per day; identify children's individual nutritional needs; ensure that each child has an ongoing source of health care; perform or obtain health, developmental and behavioral screenings; and make arrangements for mental health professionals to be available to identify mental health concerns and help locate needed treatment.[4]

Children in poor families are at greater risk for developmental delays and learning disabilities; have a greater prevalence of health and nutrition problems; and are more likely to have serious accidents, require special education, perform below grade level at school, drop out of school and earn less as adults.[5] The Head Start program succeeds in narrowing the gap between disadvantaged children and other children in vocabulary, writing, math skills, and social skills, with the greatest gains among the most disadvantaged children.[6] Long-term improvements include reduced rates of grade retention and need for special education services and increased rates of high school graduation.[7]

Comprehensive Child Care Networks

◆ Because Head Start is available to only half of Rhode Island's lowest-income children, resources were appropriated under Starting RIght (Rhode Island's 1998 child care law) to create Comprehensive Child Care Networks in underserved communities.

◆ Comprehensive Child Care Networks are based on Head Start performance standards and provide a developmentally-appropriate education program; transition assistance among programs and schools; health and mental health services; support for children with disabilities; nutrition services; family education and empowerment; and services that expand community linkages and partnerships.[8,9]

◆ Comprehensive Child Care Networks began providing services in 2001. As of January 1, 2003 services were being provided to 260 children. The goal is to serve 300-350 children by the end of fiscal year 2003.[10] Children in the lowest-income families are prioritized for services to ensure that the most disadvantaged children receive the services they need to start school ready to learn.[11]

Early Head Start

◆ Early Head Start is a federally-funded program designed to provide high-quality child and family development services to low-income families with infants and toddlers. Early Head Start has demonstrated positive impacts on children including improved cognition, language development, and social-emotional functioning. The program improves parenting and promotes parental progress as evidenced by increased rates of participation in education, training and employment.[12]

◆ In Rhode Island, as of October 2002, there were 367 families and 409 children receiving Early Head Start services.[13]

Table 24. **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 2002**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	10	3	30%
Bristol	50	20	40%
Burrillville	36	25	69%
Central Falls	280	91	33%
Charlestown	6	10	100%
Coventry	51	40	78%
Cranston	147	228	100%
Cumberland	34	5	15%
East Greenwich	28	7	25%
East Providence	139	86	62%
Exeter	25	1	4%
Foster	0	2	NA
Glocester	15	6	40%
Hopkinton	15	4	27%
Jamestown	0	1	NA
Johnston	55	45	82%
Lincoln	24	5	21%
Little Compton	3	0	100%
Middletown	30	36	100%
Narragansett	17	9	53%
New Shoreham	1	0	0%
Newport	218	127	58%
North Kingstown	87	28	32%
North Providence	63	45	71%
North Smithfield	16	1	6%
Pawtucket	598	198	33%
Portsmouth	24	11	46%
Providence	2,075	914	44%
Richmond	7	3	43%
Scituate	9	4	44%
Smithfield	5	12	100%
South Kingstown	31	26	84%
Tiverton	15	28	100%
Warren	15	18	100%
Warwick	133	158	100%
West Greenwich	7	0	0%
West Warwick	209	143	68%
Westerly	56	57	100%
Woonsocket	455	237	52%
Core Cities	*3,835*	*1,710*	*45%*
Remainder of State	*1,156*	*924*	*80%*
Rhode Island	*4,991*	*2,634*	*53%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 2002.

The denominator is the estimated number of eligible children based on the number of three and four-year-old children in each community times the poverty rate for children under 5 in that community, according to Census 2000.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

References for Indicator

[1,4] *Head Start Fact Sheet* (2001). Washington, DC: Administration for Children and Families.

[2] Administration for Children and Families. Program Instruction: Receipt of Public Assistance and Determining Eligibility for Head Start (Log No. ACYF-PI-HS-99-06), 7/29/99.

[3] Head Start Program Regulations and Program Guidance (45 CFR 1304, 1305).

[5] Sherman, A (1997). *Poverty Matters: The Cost of Child Poverty in America*. Washington, DC: The Children's Defense Fund.

[6] *Head Start FACES: Longitudinal Findings on Program Performance (Third Progress Report)* (January 2001). Washington, DC: U.S. Department of Health and Human Services.

[7] Barnett, W.S. (2002). *The Battle Over Head Start: What the Research Shows*. New Brunswick, NJ: Rutgers University, National Institute for Early Education Research.

[8] Article 11 Relating to the Starting Right Initiative, Section 42-12-26.

[9,11] *Certification Standards for Comprehensive Child Care Services Networks (December 1999)*. Providence, RI: Rhode Island Department of Human Services, Center for Children and Families, Office of Child Care.

[10] Rhode Island Department of Health and Human Services, January 1, 2003.

[12] *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start (Executive Summary)* (June 2002). Washington, DC: Administration for Children and Families, Department of Health and Human Services.

[13] Rhode Island Early Head Start Programs, children enrolled on October 1, 2002.

School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 6 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 6 to 12 that do not require licensing by the state.

SIGNIFICANCE

Many parents need care for their school-age children during work hours. Children spend only 20% of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20 or more hours per week.[1] Many children are alone during the hours before and after school. It is estimated that nationally 8 million children ages 5 to 14 spend time without adult supervision on a regular basis.[2] During the summer, children spend a significantly longer amount of time in self-care than during the rest of the year and are thus at increased risk of physical injury and psychological or emotional harm.[3]

Children who are without adult supervision when school is out are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[4,5] Low-income children and children in urban or high-crime neighborhoods are most at risk when they spend time caring for themselves and are most likely to benefit from high quality after-school programming.[6]

When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities – homework and reading help, sports, music, theater, art – and the opportunity to build meaningful relationships with their peers and caring adults.[7] Programs for older youth can be particularly successful if they treat youth as a resource and provide opportunities to contribute to the community.[8]

After-school programs are cost-effective, returning $2-$4 for every dollar spent, due to a variety of positive effects including improved academic performance, reduced crime and reduced welfare costs.[9] Children in high quality, well-designed after-school programs and extracurricular activities have better peer relations, emotional adjustment, grades, and conduct in school than their peers without such opportunities. They are less likely to use drugs or become teen parents.[10,11] Yet, many programs are of poor quality due to a lack of resources, staff turnover, and inappropriate space. Resources are particularly scarce in low-income communities where they are needed most.[12,13,14]

Supporting Children with Special Needs

◆ According to a recent Rhode Island Department of Health survey of child care providers serving children of all ages, 44% of center-based child care providers who responded indicated that they had asked a child to leave within the last 6 months, primarily due to behavioral problems.[15]

◆ Few providers of child care or youth care have the training to provide care to children with special needs. The Rhode Island Department of Human Services is currently finalizing standards for the provision of Therapeutic Services in Child Care and Youth Care. The program will provide supports and services that children with moderate to severe special needs require in order to participate successfully in child care and youth care settings.[16]

Out-of-School Time and After-School Programs

◆ In Rhode Island, the number of licensed school-age child care slots for children ages 6 to 12 increased from 6,692 in 1996 to 12,117 in 2002.

◆ Quality after-school programs can provide safe, engaging environments that improve children's academic achievement and self-confidence, promote healthy development and peer relationships, and decrease television viewing, drug and alcohol abuse and juvenile crime.[17]

◆ Exemplary after-school programs are well-managed, employ qualified staff, forge effective community and family partnerships, provide enriching learning opportunities, pay attention to safety, health and nutrition, coordinate activities with those provided in school, and include an evaluation and improvement component.[18]

◆ A recent study on out-of-school time in Providence found that demand for out-of-school opportunities continues to exceed supply, coordination among programs is limited, the quality of programming varies widely, and lack of transportation is a barrier to participation. Inadequate, uncoordinated and unstable funding undermines the success of some out-of-school time programs for youth. Child care subsidies are not being accessed for older children because few programs for school-age children are licensed.[19]

Table 25.

Licensed School-Age Child Care for Children Ages 6 to 12, Rhode Island, 2002

CITY/TOWN	PROGRAMS	SLOTS
Barrington	4	183
Bristol	5	186
Burrillville	1	38
Central Falls	5	245
Charlestown	1	26
Coventry	6	279
Cranston	18	582
Cumberland	5	225
East Greenwich	2	55
East Providence	14	718
Exeter	3	80
Foster	2	68
Glocester	1	75
Hopkinton	0	0
Jamestown	1	50
Johnston	5	165
Lincoln	11	484
Little Compton	1	26
Middletown	5	196
Narragansett	1	60
New Shoreham	0	0
Newport	8	336
North Kingstown	12	549
North Providence	2	150
North Smithfield	1	100
Pawtucket	14	1,123
Portsmouth	2	191
Providence	43	2,968
Richmond	0	0
Scituate	1	25
Smithfield	2	120
South Kingstown	5	216
Tiverton	2	95
Warren	4	235
Warwick	24	1,095
West Greenwich	2	36
West Warwick	7	390
Westerly	10	354
Woonsocket	10	393
Core Cities	*87*	*5,455*
Remainder of State	*153*	*6,662*
Rhode Island	*240*	*12,117*

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 2002.

Number of licensed school-age child care programs and slots for children ages 6 to 12 as of December 2002. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 6 to 12 that do not require licensing by the state. Licensed school-age child care programs also provide service to 5 year old children who are enrolled in Kindergarten. The community-based/school-based breakdowns that appeared in previous factbooks are not available for 2002.

References for Indicator

1 *Fact Sheet on School-Age Children's Out-of-School Time* (March 2001). Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

2,3,5,11 *Fact Sheet on School-Age Children's Out-of-School Time* (January 2003). Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

3 Capizzano, J. et al. (2002). *What Happens When the School Year is Over? The Use and Costs of Child Care for School-Age Children during the Summer Months*. Washington D.C.: The Urban Institute.

4 *A Matter of Time: Risk and Opportunity in the Out-of-School Hours* (1994). New York, NY: Carnegie Corporation, Carnegie Council on Adolescent Development.

6 Vandell, D.L., et al. "After-School Child Care Programs" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

7,9 *Making an Impact on Out-of-School Time* (June 2000). Wellesley, MA: National Institute on Out-of-School Time.

8,10 Quinn, J. "Where Need Meets Opportunity: Youth Development Programs for Early Teens" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

12 Halpern, R. "After-School Programs for Low-Income Children: Promise and Challenges" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

13 *Working for Children and Families: Safe and Smart After-School Programs* (April 2000). Washington, DC: U.S. Department of Education, Partnership for Family Involvement in Education.

14 "Child Care Health Survey Results" (Power Point Presentation)(December 2002). Rhode Island Department of Health, Emotional Health in Child Care Committee.

15 *Certification Standards: Providers of Therapeutic Services in Child Care and Youth Care* (Draft, January 2003). Cranston, RI: Department of Human Services.

16,18 *After-School Programs: Keeping Children Safe and Smart* (2000). Washington, DC: U.S. Department of Education.

17 *Stepping Up! Out of School Time and Youth Development in Providence: A School-Community Analysis*. (January 2003). Prepared by Community Matters for the Providence School Department and United Way of Rhode Island.

Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies can be used for care by a child care center, family child care home, a relative, or an in-home caregiver.

SIGNIFICANCE

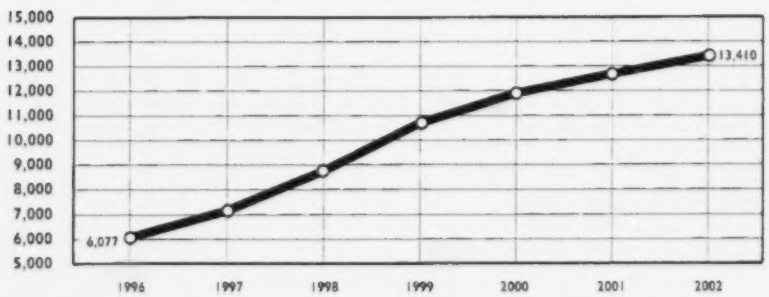
Families rely on child care to enable them to work and to provide the early education experiences needed to prepare their children for school.[1] Yet the high cost of child care puts quality care out of reach for many families, particularly low-income families.[2] National studies have shown that child care subsidies increase the likelihood that low-income parents, particularly current or former welfare recipients, will be able to work.[3]

In 1997, U.S. families with earnings below the federal poverty level who paid for child care spent 23% of their earnings, low-income families spent 16% of their earnings and higher-income families spent 6% of their earnings for child care. Families with younger children spent a higher share of income on child care than families with older children.[4] Low-skilled single mothers who pay for child care spend the highest proportion of their income on child care.[5]

The quality and stability of child care is critical to a parent's ability to work and to child development.[6,7] Parents of children in quality child care programs are more likely to be productive workers because they are less hampered by child care problems that result in frequent employee turnover and absenteeism.[8]

Rhode Island is the only state that has a legal entitlement to a child care subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty line are entitled to a child care subsidy for their children through age 16. Co-payments are required for families with income over the federal poverty guidelines. Reimbursement rates for child care providers who accept subsidies are set at the 75th percentile of the child care market rate in order to provide low-income families with access to a large proportion of the child care that exists, including higher quality care.[9,10] A recent study estimates that 18,302 Rhode Island families qualify for child care subsidies.[11] In 2002 in Rhode Island, there were 13,410 children in 8,102 families receiving child care subsidies.[12]

Child Care Subsidies, Rhode Island, 1996-2002



Source: Rhode Island Department of Human Services, December 1996-December 2002.

◆ The number of children receiving child care subsidies has increased from 6,077 in December of 1996 to 13,410 in December of 2002. In 2002, ninety-three percent of Rhode Island families receiving child care subsidies chose licensed child care centers or certified family child care homes for their child care arrangements.[13]

◆ The high cost of child care disproportionately affects the lowest income families. Low-income families that pay for child care spend an average of $1 in every $7 of earnings to purchase that care. Child care subsidies broaden a family's employment options, broaden the child care options available to families, improve access to higher quality care, and alleviate the financial burden of child care.[14]

◆ In December 2002, 71% of all child care subsidies in Rhode Island were being used by low-income working families not receiving cash assistance and 24% were being used by families receiving cash assistance through the Family Independence Program (FIP) and who were engaged in education, training or employment.[15]

Table 26.

Child Care Subsidies, Rhode Island, 2002

CITY/TOWN	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 IN WORKING FAMILIES < 185% POVERTY	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 ENROLLED IN FIP	NUMBER OF CHILD CARE SUBSIDIES: UNDER AGE 3	AGES 3-5	AGES 6-11	AGES 12-16	TOTAL CHILD CARE SUBSIDIES
Barrington	189	22	6	10	35	1	52
Bristol	586	138	21	23	29	0	73
Burrillville	389	115	4	13	22	1	40
Central Falls	1,773	1,503	61	82	65	5	213
Charlestown	231	57	3	7	3	0	13
Coventry	793	245	45	72	65	3	185
Cranston	2,336	931	199	268	292	25	784
Cumberland	632	157	35	47	12	0	94
East Greenwich	137	65	39	57	13	1	110
East Providence	1,895	619	124	234	201	16	575
Exeter	171	42	2	10	0	0	12
Foster	129	20	2	8	11	0	21
Glocester	263	42	12	11	3	0	26
Hopkinton	267	32	7	6	0	0	13
Jamestown	81	21	2	4	4	0	10
Johnston	856	309	48	81	68	2	199
Lincoln	459	135	44	54	62	4	164
Little Compton	38	13	0	0	0	0	0
Middletown	657	95	68	120	30	0	218
Narragansett	322	81	13	22	22	3	60
New Shoreham	19	0	0	0	0	0	0
Newport	1,372	908	74	91	89	6	260
North Kingstown	833	236	39	63	117	4	223
North Providence	823	353	55	92	78	9	234
North Smithfield	132	38	5	6	11	0	22
Pawtucket	5,059	2,907	320	591	713	61	1,685
Portsmouth	329	49	9	11	18	1	39
Providence	13,712	13,240	1,412	1,635	1,966	267	5,280
Richmond	170	32	4	1	5	0	10
Scituate	175	40	4	13	14	0	31
Smithfield	330	52	27	58	31	2	118
South Kingstown	423	206	45	73	36	3	157
Tiverton	248	103	8	21	21	0	50
Warren	412	132	59	72	61	2	194
Warwick	2,136	724	300	421	336	25	1,082
West Greenwich	121	23	21	22	8	1	52
West Warwick	1,568	537	53	97	131	4	285
Westerly	875	244	13	60	44	0	117
Woonsocket	2,926	2,029	135	195	162	22	514
Out-of-State	*NA*	*0*	*26*	*48*	*14*	*1*	*89*
Core Cities	*26,410*	*21,124*	*2,055*	*2,691*	*3,126*	*365*	*8,237*
Remainder of State	*17,457*	*5,371*	*1,289*	*2,008*	*1,666*	*104*	*5,067*
Rhode Island	*43,867*	*26,495*	*3,344*	*4,699*	*4,792*	*469**	*13,304*

FIP is the Family Independence Program.

Notes to Table

*Of these, 20 subsidies were used by youth ages 15 and 16. The small number of subsidies for youth is due in part to the fact that many out-of-school time programs serving older youth are not certified as child care providers.

Source of Data for Table/Methodology

The Rhode Island Department of Human Services, INRHODES Database, December 1, 2002. All data are reported by location of the child care program not the residence of the child. Data in this table does not include retroactive payments made in December and may therefore differ slightly from data reported on the previous page. Also see methodology on page 125.

References for Indicator

[1] Schulman, K., et al (November 2001). *A Fragile Foundation: State Child Care Assistance Policies.* Washington, DC: Children's Defense Fund.

[2] Schulman, K. (2000). *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families.* Washington, DC: Children's Defense Fund.

[3] Blau, D. et. al. (January 2001). *The Determinants and Consequences of Child Care Subsidy Receipt by Low-Income Families.* Chapel Hill, NC: Department of Economics, University of North Carolina, Chapel Hill.

[4] Giannarelli, L. (2000). *Child Care Expenses of America's Families.* Washington, DC: The Urban Institute.

[5] Anderson, P.M. et al (2000). "Child Care and Mothers Employment Decisions." In *Finding Jobs.* New York: Russ." Sage Foundation.

[6] Culkin, M.L., et al (December 1997). *Building Blocks: A Legislator's Guide to Child Care Policy.* Denver, CO: National Conference of State Legislatures.

[7] Starting Points: *Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[8] *Why Child Care Matters* (1993). New York, NY: The Committee for Economic Development.

[9] *Rhode Island KIDS COUNT Special Report. Building an Early Care and Education System in Rhode Island* (December 1999). Providence, RI: Rhode Island KIDS COUNT.

[10] *Starting Right: Quality Early Education and Child Care for Rhode Island's Children and Youth* (July 2000). Cranston, RI: Rhode Island Department of Human Services.

Continued on page 126

Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school kindergarten children enrolled in a full-day kindergarten program as of October 2, 2002. Full-day kindergarten is defined as a kindergarten program that operates for at least six hours per day. The numbers do not include children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care.

SIGNIFICANCE

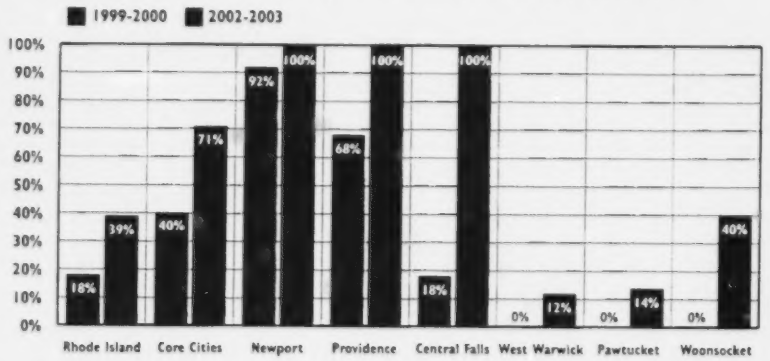
Research shows that many children benefit academically from participation in full-day kindergarten and are more likely to be ready for first grade than children in half-day kindergarten programs.[1,2] Full-day kindergarten programs are especially beneficial to children from low-income and educationally disadvantaged backgrounds.[3]

The increase in single parent families, the increase in the number of families with both parents working, and the fact that most children have experience with full-day preschool or child care programs have increased the demand for full-day kindergarten. Studies show that parents favor a full-day program that reduces the number of transitions that their kindergarten child must make each day.[4]

Teachers and parents report that children in full-day programs have more time to discover at a relaxed pace, more opportunities to choose activities and develop their own interests, and more time for creative activities.[5] The longer school day allows children and teachers time to explore topics in depth; reduces the ratio of transition time to class time; provides for greater continuity of daily activities; and provides an environment that supports a child-centered, developmentally-appropriate approach. Full-day kindergartners exhibit more independent learning, classroom involvement, productivity in work with peers, and reflectiveness than half-day kindergartners.[6] Children in full-day programs are more likely to understand a broader range of letter-sound relationships, recognize words by sight, and understand words in context.[7]

Teachers in full-day programs are better able to assess children's progress.[8] In a full-day program, teachers and school staff have more opportunities to recognize a child's learning style and identify problems or behavioral issues. This allows for more timely intervention and the potential to reduce costs associated with remedial education and special education costs in later school years.[9]

Children in Full-Day Public Kindergarten Programs, Core Cities and Rhode Island, 1999-2000 and 2002-2003



Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2002-2003 school years.

◆ In Rhode Island in 2002-2003, 39% of children who attended kindergarten were in a full-day kindergarten, up from 33% in 2001-2002 and 18% in 1999-2000.[10] Nationwide, approximately 50% of kindergarteners attend a full-day program.[11,12]

◆ Almost three-quarters (71%) of children in the six core cities attended full-day kindergarten programs in 2002-2003, an increase from 69% in 2001-2002, 56% in 2000-2001, and 40% in 1999-2000.[13]

◆ Of Rhode Island's thirty-six school districts, six offer universal access to full-day kindergarten. The remaining school districts with full-day kindergarten select children for the full-day program by residence, lottery or based on special needs or risk categories.[14]

◆ Full-day kindergarten helps to level academic disparities among students as they enter the first grade. Research indicates that children who attend full-day kindergarten score higher on first grade reading readiness tests and on reading and achievement tests in the elementary grades.[15,16]

Pirate Story

Three of us afloat in the meadow by the swing,
Three of us aboard in the basket on the lea.
Winds are in the air, they are blowing in the spring;
And waves are on the meadow like the waves there are at sea.

Where shall we adventure, to-day that we're afloat,
Wary of the weather and steering by a star?
Shall it be to Africa, a-steering of the boat,
To Providence, or Babylon, or off to Malabar?

Ho! But there's a squadron a-rowing on the sea –
Cattle on the meadow a-charging with a roar!
Quick, and we'll escape them, they're as mad as they can be.
The wicket is the harbour and the garden is the shore.

Robert Louis Stevenson

Table 27. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 1999-2000 and 2002-2003**

SCHOOL DISTRICT	1999-2000 SCHOOL YEAR			2002-2003 SCHOOL YEAR		
	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL DAY K	% CHILDREN IN FULL DAY K
Barrington	214	0	0%	203	5	2%
Bristol-Warren	255	0	0%	241	35	15%
Burrillville	164	0	0%	142	83	58%
Central Falls	250	44	18%	284	284	100%
Chariho	292	0	0%	265	46	17%
Coventry	381	0	0%	367	0	0%
Cranston	737	0	0%	695	0	0%
Cumberland	373	0	0%	391	15	4%
East Greenwich	165	0	0%	148	0	0%
East Providence	443	0	0%	414	52	13%
Exeter-W. Greenwich	129	0	0%	120	0	0%
Foster	55	0	0%	49	0	0%
Foster-Glocester	0	0	0%	0	0	0%
Glocester	124	0	0%	101	0	0%
Jamestown	59	0	0%	41	39	95%
Johnston	241	0	0%	218	0	0%
Lincoln	232	0	0%	246	0	0%
Little Compton	38	0	0%	33	0	0%
Middletown	258	211	82%	234	234	100%
Narragansett	125	0	0%	120	98	82%
New Shoreham	8	8	100%	266	266	100%
Newport	225	206	92%	17	17	100%
North Kingstown	313	0	0%	312	45	14%
North Providence	211	0	0%	174	0	0%
North Smithfield	122	55	45%	138	138	100%
Pawtucket	788	0	0%	678	94	14%
Portsmouth	214	0	0%	176	0	0%
Providence	2,117	1,431	68%	2,002	2,002	100%
Scituate	107	0	0%	124	15	12%
Smithfield	177	0	0%	124	0	0%
South Kingstown	278	0	0%	207	22	11%
Tiverton	144	0	0%	127	0	0%
Warwick	766	29	4%	720	47	7%
West Warwick	260	0	0%	269	205	76%
Westerly	282	10	4%	253	30	12%
Woonsocket	522	0	0%	618	248	40%
State Run Schools	*NA*	*NA*	*NA*	*5*	*5*	*100%*
Charter Schools	*NA*	*NA*	*NA*	*167*	*132*	*79%*
Core Cities	*4,162*	*1,681*	*40%*	*4,101*	*2,924*	*71%*
Remainder of State	*6,907*	*313*	*5%*	*6,588*	*1,233*	*19%*
Rhode Island	*11,069*	*1,994*	*18%*	*10,689*	*4,157*	*39%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education. 1999 and 2002. Data are as of October 1999 and 2002 and are for the 1999-2000 and 2002-2003 school years.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] [2] Clark, P. (June 2001). "Recent Research on All-Day Kindergarten." in *ERIC DIGEST*. Champaign, IL: ERIC Clearinghouse on Elementary and Early Childhood Education.

[3] Hildebrand, C. (Fall 2000). "Effects of All-Day and Half-Day Kindergarten Programming On Reading, Writing, Math, and Classroom Social Behaviors." *National FORUM of Applied Educational Research Journal*, Volume 13E, No.3. Lake Charles, LA: The College of Education and Human Development, University of Louisiana at Monroe.

[4] [5] *Learning to Learn: Full-Day Kindergarten for At-Risk Kids* (Revised, October 2000). Harrisburg, PA: Pennsylvania Partnership for Children.

[6] Miller, A. "Full-Day Kindergarten". *Parent News for January-February 2001* (2001). Champaign, IL: National Parent Information Network, ERIC Clearinghouse on Elementary and Early Childhood Education.

[7] [8] West, J. et al (2000). *The Kindergarten Year: Findings from the Early Childhood Longitudinal Study, Kindergarten Class of 1998-99*.

[9] *Narrowing the Gap in Early Literacy: Evidence from Minneapolis Public Schools Kindergarten Assessments* (November 2002). Minneapolis, MN: Minneapolis Public Schools.

[10] [11] [12] [13] Rhode Island Department of Elementary and Secondary Education. 2000, 2001, 2002 and 2003.

English Language Learners

DEFINITION

English language learners is the percentage of all public school children (pre-kindergarten through grade 12) who are receiving English as a Second Language services or Bilingual Education services in Rhode Island public elementary and secondary schools. The term "Limited English Proficient students" has been replaced by the term "English language learners" in the education community.

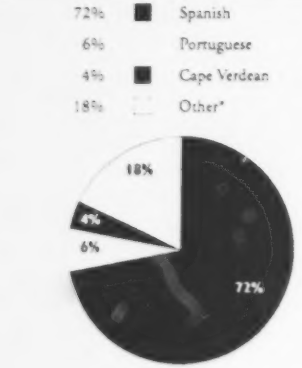
SIGNIFICANCE

Children of recent immigrants are at very high risk for difficulties at school. They face multiple risk factors including poverty, non-English speaking backgrounds, low educational level of parents, and discrimination based on race, ethnic background, culture, or language.[1] Adults who report that they have some difficulty with English are twelve times as likely to have completed less than five years of schooling and half as likely to have graduated from high school. Children who live in these households are fifty percent more likely to live in poverty.[2] These children are also most likely to be concentrated in underresourced schools in high poverty communities.[3] Children who speak languages other than English at home and who also have difficulty speaking English face greater challenges progressing in school and in the workforce.[4]

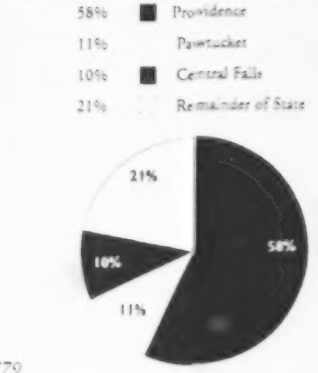
Schools play a critical role in helping children to transition to the culture of the United States and in providing an education that supports academic success for children with a primary language other than English.[5] The Rhode Island Department of Education is legally mandated to provide programs to English language learners that are comparable in structure and content to instruction provided to their English proficient peers. Programs must focus on full English language literacy and all programs must have a process for evaluating the adequate yearly progress of each English language learner, including those who have left the English as a Second Language (ESL) system.[6]

The number of Rhode Island public school students who are English language learners has increased from 6,494 students in 1990-1991 to 10,779 students in 2001-2002. Nearly all of the increase has been in the school districts of the core cities. During the 2001-2002 school year, nearly 4 out of 5 English language learners in Rhode Island went to school in the cities of Central Falls, Pawtucket and Providence.[7,8]

English Language Learners, by Language, Rhode Island, 2002



English Language Learners, by Community, Rhode Island, 2002



n = 10,779

**Includes Arabic, Armenian, Cambodian, Chinese, French, Korean, Laotian, Polish, Russian, Vietnamese, Haitian/Creole, and others.*

Source: Rhode Island Department of Elementary and Secondary Education.

◆ Spanish is the most commonly spoken language of Rhode Island's public school students who are English language learners. This is consistent with the increase in the Latino child population in Rhode Island, from 16,000 in 1990 to 35,000 in 2000.[9]

◆ Compared to students of other racial/ethnic groups, Latino high school students in Rhode Island have the lowest achievement ratings in math, reading and writing.[10] Nearly one-third of all students attending low-performing schools are Latino. Eighty-five percent of Rhode Island's Latino students attend a low-performing school.[11]

◆ To improve educational outcomes for Latino students, schools can increase academic expectations, place Latino students in special education only when appropriate, develop culturally-rich curricula and deliberately talk with Latino students about the courses they choose and postsecondary options.[12]

Table 28.

English Language Learners, Rhode Island, 2001-2002

SCHOOL DISTRICT	TOTAL ENROLLMENT IN DISTRICT	NUMBER OF ENGLISH LANGUAGE LEARNERS (ELL) PRE K AND K	ELEMENTARY GRADES 1-5	MIDDLE GRADES 6-8	HIGH GRADES 9-12	TOTAL ELL	% OF TOTAL DISTRICT
Barrington	3,286	0	5	0	2	7	<1%
Bristol-Warren	3,810	25	86	22	9	142	4%
Burrillville	2,749	0	1	2	1	4	<1%
Central Falls	3,638	87	530	274	209	1,100	30%
Chariho	3,887	1	8	2	7	18	<1%
Coventry	5,785	4	12	1	5	22	<1%
Cranston	11,155	37	236	113	89	475	4%
Cumberland	5,373	10	105	38	26	184	3%
East Greenwich	2,440	4	14	5	4	27	1%
East Providence	6,566	69	185	52	40	346	5%
Exeter-W. Greenwich	2,152	3	4	2	3	12	1%
Foster	402	0	0	0	0	0	0%
Foster-Glocester	1,632	0	0	0	0	0	0%
Glocester	802	0	0	0	0	0	0%
Jamestown	588	0	1	0	0	1	<1%
Johnston	3,381	3	33	14	11	61	2%
Lincoln	3,706	4	10	5	9	28	1%
Little Compton	350	0	0	0	0	0	0%
Middletown	2,856	2	15	8	13	38	1%
Narragansett	1,742	0	6	0	1	7	<1%
New Shoreham	130	0	2	0	0	2	2%
Newport	2,937	1	41	20	19	81	3%
North Kingstown	4,501	9	26	9	14	58	1%
North Providence	3,476	0	60	22	26	115	3%
North Smithfield	1,861	0	0	1	0	1	<1%
Pawtucket	9,833	110	482	312	292	1,196	12%
Portsmouth	2,888	0	0	0	0	0	0%
Providence	27,159	690	3,577	1,097	787	6,195	23%
Scituate	1,772	0	0	0	0	0	0%
Smithfield	2,733	0	0	0	0	0	0%
South Kingstown	4,344	1	26	14	9	50	1%
Tiverton	2,222	0	1	2	0	3	<1%
Warwick	12,222	8	41	16	13	78	1%
West Warwick	3,795	22	32	14	13	81	2%
Westerly	3,691	16	29	16	12	73	2%
Woonsocket	6,760	47	237	58	31	374	6%
Core Cities	*54,122*	*957*	*4,899*	*1,775*	*1,351*	*9,027*	*17%*
Remainder of State	*102,502*	*196*	*906*	*344*	*294*	*1,752*	*2%*
Rhode Island	*156,624*	*1,153*	*5,805*	*2,119*	*1,645*	*10,779**	*7%*

** Includes 57 students in ungraded classes from Cumberland (5), North Providence (7), Providence (44) and Woonsocket (1).*

Sources of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year. Total number of English language learners is the number of students in each district who were actively enrolled in English as a Second Language (ESL) or Bilingual Education Programs in the 2001-2002 school year. Students who are not yet fully English proficient but have exited the ESL or bilingual program to regular education are not included in these numbers. Denominator is the fall enrollment figures by district.

References

[1] *Informanon Works!* (2000). Providence RI: Rhode Island Department of Elementary and Secondary Education and University of Rhode Island, National Center on Public Education and Social Policy.

[2] Crawford, James (1997). *Best Evidence: Research Foundations for the Bilingual Education*. Washington DC: National Clearinghouse for Bilingual Education.

[3] Ruiz-de-Velasco, J. and Fix, M. (2001). *Overlooked and Underserved: Immigrant Students in U.S. Secondary Schools*. Washington, DC: Urban Institute.

[4] *Ammual Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[5] Rhode Island Department of Elementary and Secondary Education, Limited English Proficiency (LEP) Regulations Chapter 16-54, 2000.

[6] *Results: Education in Rhode Island 2001* (2001). Rhode Island Public Expenditure Council, Providence, RI and the Rhode Island Department of Elementary and Secondary Education.

[7,8] Rhode Island Department of Elementary and Secondary Education, 2001-2002 and 1998-2000.

[9] US Bureau of the Census, Census 2000.

[10] Uriarte, M., et al. (2002). *Rhode Island Latinos: A Scan of Issues Affecting the Latino Population of Rhode Island*. Boston, MA: Mauricio Gaston Institute, University of Massachusetts, Boston.

Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the number of children ages 3 to 21 who are enrolled in special education in Rhode Island elementary and secondary schools.

SIGNIFICANCE

Special education services are an important resource for improving long-term outcomes for children with special needs, such as improving student achievement and graduation rates, increasing participation in postsecondary education, increasing wages, and reducing disproportionately high rates of single parenthood.[1,2,3]

The federal Individuals with Disabilities Education Act (IDEA) mandates that local school districts identify and provide multidisciplinary evaluations for students ages 3 to 21 whom they have reason to believe have disabilities. Once found eligible for special education due to disability, a student must be provided with an Individualized Education Plan (IEP) which defines goals, outlining specific steps for achieving the goals, and providing services for the student based on their individual needs.[4]

Services described in the IEP must be provided in the least restrictive environment, i.e., to the extent appropriate, the child should receive special services in a setting that is integrated with other children with and without disabilities. This is sometimes referred to as inclusion or mainstreaming. Inclusion is meant to raise expectations for student performance, improve opportunities for the child with disabilities to learn alongside nondisabled peers, improve coordination between regular and special educators, and increase the school's accountability for performance.[5,6]

Revisions to federal educational statutes, signed into law early in 2002, now require states, districts and schools to demonstrate adequate yearly progress towards proficiency in reading and math by all students, including students with disabilities. This provision is intended to increase expectations and accountability so that more students with disabilities achieve grade-level standards.[7]

Learning Disabilities and Reading Problems in the Early Grades

◆ Of the 33,058 children receiving special education services in 2001-2002, 48% were receiving services because of learning disabilities.[8]

◆ Many of the reading difficulties that result in the identification of children as learning disabled may be prevented through early identification and intervention programs. Frequently reading problems are not identified until the third or fourth grade, just as they become intractable and require more specialized interventions.[9]

◆ Prompt intervention may prevent some children from needing costlier special education services later. A recent study of Rhode Island's special education system recommends that the growth in the numbers of children identified as learning disabled can be addressed through high-quality literacy education for all children, coupled with increased capacity for identification and intensive instructional intervention for those children who fall behind in the early grades.[10]

Meeting the Needs of Children with Severe Disabilities

◆ Children with low-incidence but severe disabilities may require intensive, highly specialized and expensive services to reach their full potential. In Rhode Island, children with the highest educational costs include those with mental retardation, multiple disabilities and autism.[11]

◆ In 2002 the President's Commission on Excellence in Special Education recommended that states be encouraged to allocate special safety net funds that would be available for schools and school districts to help educate children with the most intensive needs.[12]

◆ The Commission noted that currently small towns may face disproportionate costs, and that local education agencies with outstanding special education programs or medical facilities often become the centers of high concentrations of children with high-intensity special needs. State-based safety net funding would help distribute these costs across a larger population.[13]

Table 29

Children and Youth in Special Education, by Primary Disability, Ages 3-21, Rhode Island, 2001-2002

SCHOOL DISTRICT	TOTAL # OF STUDENTS	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	AUTISM	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOP-MENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	3,172	58	13	10	48	271	142	24	20	586	18%
Bristol-Warren	3,659	55	53	9	16	477	209	30	16	865	24%
Burrillville	2,630	77	23	14	103	200	98	21	18	554	21%
Central Falls	3,624	95	48	3	75	518	107	49	18	913	25%
Chariho	3,688	45	13	10	41	338	205	24	32	708	19%
Coventry	5,654	76	41	7	73	827	142	55	23	1,244	22%
Cranston	10,625	156	41	24	164	1,466	389	100	47	2,387	22%
Cumberland	5,159	124	34	23	303	339	315	46	42	1,226	24%
East Greenwich	2,328	27	4	21	91	149	115	20	11	438	19%
East Providence	6,270	141	60	24	316	491	336	27	45	1,440	23%
Exeter-W. Greenwich	2,060	53	14	9	107	86	137	7	7	420	20%
Foster	371	0	1	0	3	12	34	1	2	53	14%
Foster-Glocester	1,604	11	10	4	14	154	49	0	4	246	15%
Glocester	752	3	10	5	9	44	77	8	5	161	21%
Jamestown	570	4	2	8	30	56	23	7	2	132	23%
Johnston	3,256	64	26	11	146	337	234	20	18	856	26%
Lincoln	3,625	45	24	21	177	295	137	32	20	751	21%
Little Compton	329	3	1	0	4	42	22	1	3	76	23%
Middletown	2,709	46	6	16	69	282	162	5	5	591	22%
Narragansett	1,686	26	1	8	54	189	128	10	9	425	25%
New Shoreham	133	1	0	0	0	14	11	1	0	27	20%
Newport	2,868	92	10	17	30	473	94	36	34	786	27%
North Kingstown	4,182	63	18	10	31	382	223	27	22	776	19%
North Providence	3,328	86	17	11	119	314	174	43	21	785	24%
North Smithfield	1,807	21	8	3	48	161	85	10	11	347	19%
Pawtucket	9,463	245	134	55	163	1,002	472	146	40	2,257	24%
Portsmouth	2,801	37	6	20	70	177	191	2	19	522	19%
Providence	27,222	481	332	31	70	3,253	890	63	58	5,178	19%
Scituate	1,720	7	4	8	34	92	148	8	6	307	18%
Smithfield	2,624	10	9	5	68	200	157	15	11	475	18%
South Kingstown	4,144	73	22	21	114	360	232	19	27	868	21%
Tiverton	2,129	23	5	7	42	233	138	9	9	466	22%
Warwick	11,662	177	81	34	384	1,321	362	248	69	2,676	23%
West Warwick	3,622	117	18	7	19	444	208	28	25	866	24%
Westerly	3,639	88	9	25	83	290	214	27	16	752	21%
Woonsocket	6,476	218	144	17	314	544	279	66	49	1,631	25%
State Run Schools	*1,003*	*9*	*0*	*0*	*18*	*102*	*13*	*0*	*82*	*224*	*22%*
Charter Schools	*323*	*0*	*0*	*2*	*1*	*11*	*28*	*1*	*0*	*43*	*13%*
Core Cities	*53,275*	*1,248*	*686*	*130*	*671*	*6,234*	*2,050*	*388*	*224*	*11,631*	*22%*
Remainder of State	*98,316*	*1,600*	*556*	*368*	*2,761*	*9,599*	*4,889*	*847*	*540*	*21,160*	*22%*
Rhode Island	*152,917*	*2,857*	*1,242*	*500*	*3,451*	*15,946*	*6,980*	*1,236*	*846*	*33,058*	*22%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education. 2000-2001 school year. Office of Special Education, June 30, 2002. The denominator (number of students) is the "resident average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

"Other" includes deaf and blind, visually impaired or blind, hearing impaired, multi-handicapped, orthopedically impaired, and traumatic brain injury.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Children attending schools out-of-district (e.g. when no appropriate placement exists in the district) are listed under the enrolling and not sending district.

References

[1] Terman, et al. (Spring 1996). "Special Education for Students with Disabilities: Analysis and Recommendations" in *Special Education for Students with Disabilities*. Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[2] *Twenty-five Years of Educating Children with Disabilities* (2001). Washington, DC: American Youth Policy Forum and Center on Education Policy.

[3] [4] [5] [6] *Children with Disabilities Study: Special Education in the Context of School Reform* (2002) Providence, RI: Commissioned by the Rhode Island General Assembly in July 1999.

[4] Martin, E.W. et al. "The Legislative and Litigation History of Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[5] "Quality of Education Environments"(1999) in *The Condition of Education*. Washington, DC: National Center for Education Statistics.

[6] "Quality of Education Environments" (2001) in *The Condition of Education*. Washington, DC: National Center for Education Statistics.

[7] *No State Left Behind: The Challenge and Opportunities of ESEA 2001* (March 2002). Denver, CO: Education Commission of the States.

[8] Rhode Island Department of Education, 2002.

[9] [10] *A New Era: Revitalizing Special Education for Children and Their Families* (July 1, 2002). Washington, DC: President's Commission on Excellence in Special Education.

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Student Mobility

DEFINITION

Student mobility is the number of students who either enrolled in or withdrew from Rhode Island public schools during the school year divided by the number of students in the fall school enrollment. Percentages are reported for each school district overall as well as for their elementary schools, middle schools, and high schools.

SIGNIFICANCE

One in six third grade students in the U.S. has attended at least three schools since the beginning of the first grade.[1] Student mobility affects both the student and the classrooms they attend. Changing schools causes a disruption in a child's learning experience and may accentuate learning difficulties especially if the child enters a classroom at a different point in the curriculum than in their previous school.[2]

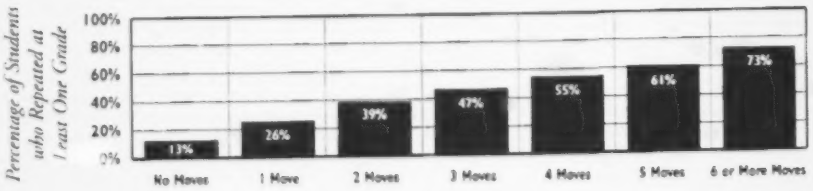
Research shows that frequent moves can have a negative affect on school performance and behavior and may affect other areas of child well-being.[3,4] Teachers in schools with highly mobile students are more likely to have difficulty accurately assessing the needs of new children, determining their past educational experiences and being able to build on the student's knowledge and skills.[5]

Nationally, children of color, children living in low-income households or renter households and immigrants have the highest rates of mobility.[6] Children who are English Language Learners (ELL) are more than twice as likely to change schools frequently as are non-ELL students.[7] Rhode Island ELL students are highly concentrated in three communities with high rates of school mobility: Central Falls, Providence and Pawtucket.[8]

The overall school mobility rate for Rhode Island was 17% for the 2001-2002 school year.[9] There was significant variation across school districts, from a high of 40% in Central Falls to a low of 3% in Jamestown.[10] The core cities, those cities with greater than 15% children living in poverty, have a significantly higher mobility rate (28%) than schools in the remainder of the state (12%).[11]

Residential mobility has a strong relationship to child well-being. Frequent moves are often correlated with such negative outcomes as dropping out of school, delinquency, depression and teen births.[12] Families move for a variety of reasons that may include changes in household structure, parental employment status, an inability to pay the rent, dissatisfication with neighborhood conditions or a desire to improve overall quality of family life.[13,14]

Students Who Repeated at Least One Grade by Number of Residential Moves, Providence, 1987 - 2001



Source: *Development and Use of Neighborhood Health Analysis: Residential Mobility in Context* (October 30, 2002). Providence, RI: The Providence Plan. Data represent the 57,641 children who were enrolled in Providence Schools between 1987 and 2001.

◆ Students in Providence who have at least one residential move are more likely to repeat a grade. As the number of moves increases, the likelihood of repeating a grade increases. Almost half (47%) of Providence students who moved 3 times had repeated a grade at least once. Almost three-quarters (73%) of children who moved 6 times had repeated a grade at least once.[15]

◆ Students with high mobility rates are less likely to meet proficiency standards in reading and math and are absent more often than those who do not move.[16]

Mobility Among Young Children Under Age 6 in Rhode Island

◆ Of all young children in Rhode Island, those born to teen mothers, single mothers or mothers with less than a high school diploma are most likely to experience residential mobility. Children living in the core cities are almost twice as likely to move as children living in the remainder of the state.[17]

◆ A study of Rhode Island children under age 6 found that residentially-mobile children have fewer office visits, less contact with a physician, and are more likely to see multiple physicians than other children.[18]

Table 30

School Mobility by District, Rhode Island, School Year 2001-2002

DISTRICT	ELEMENTARY SCHOOLS	MIDDLE / JUNIOR HIGH SCHOOLS	HIGH SCHOOLS	TOTAL DISTRICT MOBILITY
Barrington	3%	4%	6%	4%
Bristol-Warren	16%	7%	14%	13%
Burrillville	15%	17%	6%	12%
Central Falls	41%	37%	41%	40%
Chariho	10%	10%	4%	9%
Coventry	10%	5%	8%	8%
Cranston	16%	13%	19%	16%
Cumberland	7%	7%	7%	7%
East Greenwich	6%	5%	5%	6%
East Providence	17%	24%	12%	17%
Exeter-West Greenwich	6%	7%	14%	8%
Foster	6%	NA	NA	6%
Foster-Glocester	NA	16%	7%	11%
Glocester	6%	NA	NA	6%
Jamestown	3%	4%	NA	3%
Johnston	8%	9%	NA	6%
Lincoln	10%	9%	17%	12%
Little Compton	10%	NA	NA	10%
Middletown	27%	14%	17%	20%
Narragansett	10%	8%	11%	10%
New Shoreham	23%	23%	23%	23%
Newport	33%	23%	24%	28%
North Kingstown	31%	11%	9%	19%
North Providence	15%	13%	13%	14%
North Smithfield	15%	13%	13%	14%
Pawtucket	31%	21%	35%	30%
Portsmouth	17%	21%	14%	17%
Providence	31%	27%	20%	28%
Scituate	4%	4%	5%	4%
Smithfield	8%	4%	6%	7%
South Kingstown	10%	9%	7%	8%
Tiverton	9%	6%	NA	5%
Warwick	19%	10%	13%	15%
West Warwick	18%	19%	13%	17%
Westerly	13%	4%	12%	11%
Woonsocket	21%	32%	31%	26%
Core Cities	*30%*	*27%*	*26%*	*28%*
Remainder of State	*13%*	*11%*	*11%*	*12%*
Rhode Island	*19%*	*16%*	*15%*	*17%*

Sources

Mobility rates are calculated by adding all children who entered any school within the school district to all those who withdrew from a school in the district and dividing the total by the fall enrollment for that school district. If a child left one school within the district and entered another school in the same district during the school year, the child would be counted twice in the district's mobility rate. Because each district has different school configurations, mobility rates for elementary, middle/junior high and high school are not exactly comparable by grade across districts. Only schools that reported data are included in the mobility calculations for the district.

Rhode Island Department of Elementary and Secondary Education, 2001 - 2002 School Year

References for Indicator

[1,2,7] *Elementary School Children: Many Change School Frequently, Harming Their Education* (February 1994). Washington, DC: U.S. General Accounting Office.

[3] Kerbow, D. (October 1996). *Patterns of Urban Student Mobility And Local School Reform: A Technical Report*. Baltimore, MD: Center for the Social Organization of Schools, Johns Hopkins University.

[5] *Kids Mobility Project Report*. (January 2002). Minneapolis, MN: Family Housing Fund.

[6] Scanlon, E. and Devine, K. (March 2001). "Residential Mobility and Youth Well-Being: Research, Policy and Practice Issues" in *Journal of Sociology and Social Welfare*, Vol. XXVIII, Number 1.

[8] *Geographical Mobility - Population Characteristics: March 1999 to March 2000* (May 2001). Washington, DC: U.S. Bureau of the Census.

[9,10,11] Rhode Island Department of Elementary and Secondary Education, *InfoWorks! 2001-2002*.

[12] *Trends in the Well-Being of America's Children and Youth* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[13] *Why People Move: Exploring the March 2000 Current Population Survey, March 1999 to March 2000* (May 2001). Washington, DC: U.S. Bureau of the Census.

[14] *Counting on Ourselves: The Providence Demography Initiative/A First Portrait: Schools* (1999). Providence, RI: The Providence Blueprint for Education (PROBE) and The Providence Plan.

[15,16,17] *Development and Use of Neighborhood Health Analysis: Residential Mobility in Context* (October 30, 2002). Providence, RI: The Providence Plan. Data represent The Providence Plan's analysis of data from the Providence School Department student enrollment databases, the Rhode Island Department of Elementary and Secondary Education standardized test scores and the Rhode Island Department of Health Kidsnet databases.

Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the *New Standards English Language Arts Reference Exam* in 2002. The exam is made up of two parts: *Basic Understanding* focuses on the student's ability to comprehend and understand text, and *Interpretation and Analysis* focuses on the student's ability to correctly interpret and analyze text.

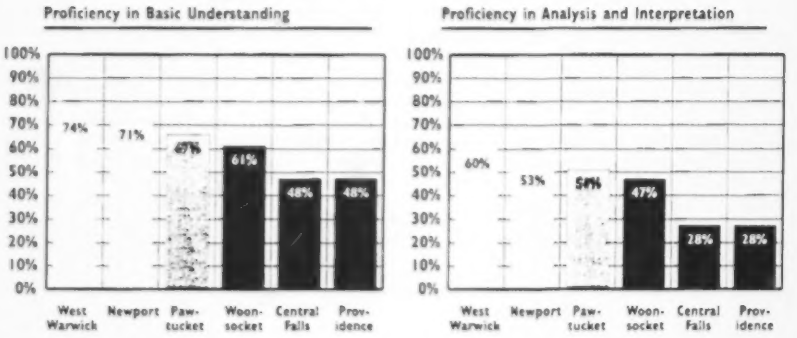
SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school. Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[1,2] In the U.S., Hispanic children face the most barriers to reading proficiency because they are more likely to be poor, less likely to attend pre-school, and more likely to have parents that have not finished high school.[3] Across the U.S., schools with high poverty rates have achieved high performance by emphasizing best practices such as standards for curriculum design and accountability; parent involvement; extra teaching time for the basics of reading and math; and immediate and intensive support for low-achieving students.[4]

Literacy begins long before children encounter formal school instruction in writing and reading. Reading to young children at home and encouraging conversation and print awareness make a difference in subsequent reading achievement.[5,6,7] Participation in high-quality pre-schools can also boost language and literacy skills by helping children learn, think, and talk about new areas of knowledge; by integrating reading, letters, sounds, and storytelling into everyday activities; and by offering opportunities to play in ways that build awareness of the sounds and structure of language.[8]

For school-age children, out-of-school activities are important predictors of reading achievement. Children who report that they regularly read for fun on their own time, children who regularly discuss their reading with family and friends, and children who watch fewer hours of television consistently outperform their peers in reading proficiency.[9,10]

Rhode Island Public School 4th Grade Reading Proficiency, Core Cities, 2001-2002



Source: RI Department of Elementary and Secondary Education, New Standards English Language Arts Reference Exam at Grade 4, 2001-2002 school year.

◆ In 2002, 74% of Rhode Island fourth graders scored at or above proficiency in *Basic Understanding* and 60% scored at or above proficiency in *Analysis and Interpretation*. Five of Rhode Island's core cities had reading proficiency levels below the state rates; one, West Warwick, matched the overall state proficiency level.[11]

◆ Between 2000-2001 and 2001-2002, each of the six core cities showed improvements in reading proficiency scores.

Reading First

◆ The Reading First Initiative is a new federal program aimed at ensuring that all students are reading at or above grade level by third grade. The initiative, part of the federal *No Child Left Behind Act of 2001*, helps states and districts implement reading programs for children and provides professional development for teachers regarding scientifically-based instruction and in the identification of children at risk of reading disabilities.

◆ Reading First targets services to districts with the highest numbers of students in kindergarten through third grade reading below grade level as well as schools with the highest number of low-income children.[13,14]

Table 31.

Fourth-Grade Reading Proficiency, Rhode Island, 2002

SCHOOL DISTRICT	COMMUNITY CONTEXT				% OF 4TH GRADE STUDENTS MEETING OR EXCEEDING STANDARDS FOR BASIC UNDERSTANDING	% OF 4TH GRADE STUDENTS MEETING OR EXCEEDING STANDARDS FOR ANALYSIS & INTERPRETATION
	% ADULTS COMPLETING HIGH SCHOOL	% CHILDREN IN POVERTY	% LIMITED ENGLISH PROFICIENCY	NUMBER OF 4TH GRADE TEST TAKERS		
Barrington	92%	4%	<1%	259	92%	84%
Bristol-Warren	NA	12%	4%	301	78%	63%
Burrillville	80%	5%	<1%	237	77%	66%
Central Falls	49%	37%	30%	310	48%	28%
Chariho	NA	6%	<1%	287	86%	74%
Coventry	83%	8%	<1%	441	79%	71%
Cranston	79%	8%	4%	926	84%	78%
Cumberland	81%	3%	3%	434	85%	75%
East Greenwich	93%	5%	1%	200	90%	82%
East Providence	71%	9%	5%	514	76%	62%
Exeter-W. Greenwich	NA	5%	1%	139	88%	75%
Foster	88%	6%	0%	78	95%	77%
Foster-Glocester	NA	4%	0%	NA*	NA	NA
Glocester	87%	8%	0%	129	87%	81%
Jamestown	93%	3%	<1%	75	88%	79%
Johnston	78%	9%	2%	271	84%	70%
Lincoln	82%	6%	1%	260	82%	72%
Little Compton	91%	1%	0%	36	92%	78%
Middletown	91%	9%	1%	208	88%	77%
Narragansett	91%	10%	<1%	123	89%	85%
New Shoreham	95%	11%	2%	12	67%	75%
Newport	87%	24%	3%	227	71%	53%
North Kingstown	92%	11%	1%	348	89%	80%
North Providence	77%	9%	3%	285	78%	63%
North Smithfield	82%	2%	<1%	163	88%	75%
Pawtucket	66%	21%	12%	783	67%	51%
Portsmouth	91%	3%	0%	224	88%	79%
Providence	66%	37%	23%	2,312	48%	28%
Scituate	87%	4%	0%	145	90%	83%
Smithfield	85%	4%	0%	216	88%	80%
South Kingstown	91%	6%	1%	339	85%	81%
Tiverton	80%	3%	<1%	202	79%	69%
Warwick	85%	8%	1%	944	81%	67%
West Warwick	76%	18%	2%	318	74%	60%
Westerly	82%	11%	2%	252	81%	70%
Woonsocket	64%	27%	6%	552	61%	47%
Core Cities	*NA*	*30%*	*17%*	*4,502*	*NA*	*NA*
Remainder of State	*NA*	*7%*	*2%*	*8,048*	*NA*	*NA*
Rhode Island	*78%*	*15%*	*7%*	*12550*	*74%*	*60%*

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1999. % of adults completing high school or higher is from Census 2000. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

*NA: Community has a regional school.

See Methodology page 125.

References for Indicator

[1,5] *America's Children: Key National Indicators of Well-Being* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2,4] Donahue, P. et al. *The Nation's Report Card. Fourth Grade Reading 2000* (April 2001). Washington, DC: National Center for Education Statistics.

[3] Fletcher, M.A., "Latinos at the Back of the Class" in *Washington Post* (December 1998), based on a report by the National Council of La Raza.

[6] Jerald, C. (2001). *Dispelling the Myth Revisited. Preliminary Findings From a Nationwide Analysis of "High-Flying" Schools*. Washington, DC: The Education Trust.

[8] *The Condition of Education 2002* (2002). Washington, DC: U.S. Department of Education, National Center for Education Statistics.

[7] *Developing and Supporting Literacy-Rich Environments for Children* (Issue Brief)(2001). Washington, DC: National Governor's Association Center for Best Practices.

[9] Dickinson, D. and Tabors, P. (2001). *Beginning Literacy with Language: Young Children Learning at Home and School*. Baltimore, MD: Paul H. Brookes Publishing Company.

[10] *Trends in the Well-Being of America's Children and Youth: 2001*. Washington, DC: U.S. Child Trends Inc., Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[11,12] Rhode Island Department of Elementary and Secondary Education, 2001 and 2002.

[13] Kauerz, K. (April 2002). *No Child Left Behind Policy Brief: Literacy*. Denver, CO: Education Commission of the States.

[14] No Child Left Behind: A Desktop Reference: www.ed.gov/offices/OESE/reference.html. (February 2003).

High Performing Schools

DEFINITION

High performing schools is the percentage of schools in Rhode Island that are categorized as high performing, defined as schools in which 50% or more of the students scored at or above standard on the *New Standards Reference Examinations* in Mathematics and English Language Arts and *The Rhode Island Writing Assessment.*

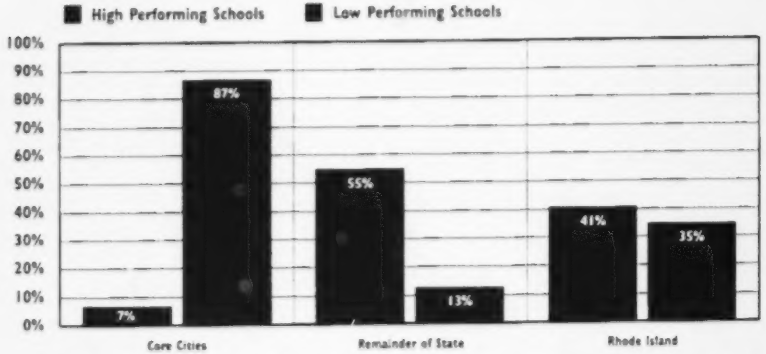
SIGNIFICANCE

Appropriate accountability systems which regularly measure student performance can improve instruction and student learning. Accountability standards make intended learning goals explicit and provide periodic feedback to parents, students, teachers, policymakers and the public.[1] It is important that performance assessments are consistent with the schools' content standards specifying what teachers are supposed to teach and what students are expected to learn.[2,3]

Rhode Island has in place an accountability program which measures the performance of students on statewide tests in every school in the areas of math, reading, writing and health. Schools in which 50% or more of the students achieve the state standards in reading, writing and math are classified as high performing; schools in which 33% or more of the students score significantly below standards or do not take the test are classified as low performing; and schools that fall between these two categories are considered moderately performing.[4,5]

In 2002, just under half (41%) of schools in Rhode Island were categorized as high-performing. Only 7% of schools in the core cities were high performing and 87% were low performing.[6] In accordance with the 2001 *No Child Left Behind Act* (the federal education law), Rhode Island must offer school choice in 14 schools in 5 districts where schools are both low performing and not improving: Central Falls, Pawtucket, Providence, Warwick and Woonsocket.[7] Students are eligible to transfer to another school if their school has been identified as being in need of improvement, corrective action or restructuring. In addition, students in these schools are eligible for free supplemental educational services, such as mentoring and tutoring. Students may also transfer to a new school if their school is identified as persistently dangerous or when a child has been the victim of a violent crime on school property.[8]

School Performance, Core Cities, Remainder of State, and Rhode Island, 2002



◆ In 2002, 41% (122) of Rhode Island schools were high-performing and 35% of schools were low performing. The number of low-performing schools in the state decreased from 115 in 2001 to 105 in 2002.[9]

◆Improvement in performance is a critical measure for schools, particularly those serving low-income students who start out with multiple disadvantages.[10] To be classified as improving, schools must both increase the percentage of children meeting standards in math or reading/writing and must decrease the percentage of children falling into the low performance range in the same area of testing.[11,12]

◆ Of the 105 low-performing schools in 2002, 51% are improving.[13] Statewide, 59% of high schools, 33% of middle schools, and 70% of elementary schools are improving.[14]

◆ Rhode Island has 35 schools that have been low performing and not improving for two consecutive years. These schools operate in 11 districts: Central Falls, Cranston, East Providence, Johnston, Newport, North Providence, Pawtucket, Providence, Warwick, West Warwick and Woonsocket. Another school is state-operated. Of these 35 schools, 25 are in the core cities.[15]

School Performance, Rhode Island, 2002

Table 32

DISTRICT	TOTAL # OF SCHOOLS	PERFORMANCE CATEGORY			NO DATA	% HIGH PERFORMING SCHOOLS	% LOW PERFORMING SCHOOLS
		HIGH	MODERATE	LOW			
Barrington	6	4	2	0	0	67%	0%
Bristol-Warren	9	2	2	4	1	25%	50%
Burrillville	5	1	3	0	1	25%	0%
Central Falls	8	0	0	6	2	0%	100%
Chariho	7	4	2	1	0	57%	14%
Coventry	8	4	4	0	0	50%	0%
Cranston	24	17	3	4	0	71%	17%
Cumberland	9	5	3	0	1	63%	0%
East Greenwich	6	4	2	0	0	67%	0%
East Providence	15	2	6	5	2	15%	38%
Exeter-W. Greenwich	5	1	2	0	2	33%	0%
Foster	1	1	0	0	0	100%	0%
Foster-Glocester	2	1	1	0	0	50%	0%
Glocester	2	2	0	0	0	100%	0%
Jamestown	2	2	0	0	0	100%	0%
Johnston	9	5	1	2	1	63%	25%
Lincoln	7	4	2	0	1	67%	0%
Little Compton	2	2	0	0	0	100%	0%
Middletown	6	2	3	0	1	40%	0%
Narragansett	3	2	1	0	0	67%	0%
New Shoreham	3	1	0	0	2	100%	0%
Newport	9	2	1	6	0	22%	67%
North Kingstown	10	7	2	0	1	78%	0%
North Providence	12	2	7	3	0	17%	25%
North Smithfield	4	1	3	0	0	25%	0%
Pawtucket	16	1	1	13	1	7%	87%
Portsmouth	6	4	1	0	1	80%	0%
Providence	49	1	1	40	7	2%	95%
Scituate	5	5	0	0	0	100%	0%
Smithfield	6	5	1	0	0	83%	0%
South Kingstown	11	5	2	0	4	71%	0%
Tiverton	6	3	3	0	0	50%	0%
Warwick	27	14	7	6	0	52%	22%
West Warwick	6	2	1	3	0	33%	50%
Westerly	7	4	3	0	0	57%	0%
Woonsocket	14	0	2	9	3	0%	82%
**Charter Schools*	*6*	*0*	*0*	*2*	*4*	*0%*	*100%*
**State Run Schools*	*2*	*0*	*0*	*1*	*1*	*0%*	*100%*
Core Cities	*102*	*6*	*6*	*77*	*13*	*7%*	*87%*
Remainder of State	*233*	*116*	*66*	*28*	*23*	*55%*	*13%*
Rhode Island	*335*	*122*	*72*	*105*	*36*	*41%*	*35%*

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Elementary and Secondary Education. School performance data are based on the past three years of test data: 2000-2002. See Methodology page 125.

Core cities are Central Falls, Pawtucket, Providence, Newport, West Warwick and Woonsocket.

References for Indicator

[1,2,3] Linn, R. (April 2001). *The Design and Evaluation of Educational Assessment and Accountability Systems (CSE Technical Report 539).* Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[2] Briars, D. (August 2000). *Standards, Assessments—and What Else? The Essential Elements of Standards-Based School Improvement. (CSE Technical Report 528).* Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[4,5] *School Performance Categories. Technical Assistance Bulletin #1* (February 2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[5,6] *Implementation of Federal Education Reform in the Ocean State (A Special Bulletin of the Rhode Island Public Expenditure Council)* (January 25, 2002). Providence, RI: Rhode Island Public Expenditure Council.

[6,7] Rhode Island Department of Elementary and Secondary Education (2002).

[8] *Public School Choice: Draft Non-Regulatory Guidance* (December 2002). Washington, DC: U.S. Department of Education.

[9,10,11] *School-Performance Categories – 2002: Statewide Summary and Factsheet* (December 2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[12] *2002 Low-Performing and Not Improving Schools – Two Years* (2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.[8] Rhode Island Department of Elementary and Secondary Education, School Performance Categories, District Profile 1998-2001.

School Attendance

DEFINITION

School attendance is the average daily attendance of public school students in each school district in Rhode Island for elementary school (grades 1-5), middle school (grades 6-8), and high school (grades 9-12). Public school students in pre-school, kindergarten, and ungraded classrooms are not included.

SIGNIFICANCE

An important aspect of students' access to education is the amount of time actually spent in the classroom. When students are absent from school they forgo opportunities to learn.[1] Lower attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[2,3] Absenteeism is detrimental to student's achievement. Students who miss school fall behind their peers in the classroom.[4] Students who think of dropping out have already begun skipping school occasionally.[5] Truancy among teens is a powerful predictor of juvenile delinquency and may be connected with substance abuse and other illegal activities.[6,7]

Problems with student attendance create a climate of instability in schools. In schools where truancy rates are low, there is less disruption and violence, teachers are more committed to students and are more likely to interact and engage with the entire class. Students are less likely to miss school when they are engaged and have a sense of belonging due to established relationships with both their teachers and classmates.[8]

Student absenteeism places individual children at risk for school failure. Truancy is rarely a reflection of the child alone and is often the first indication that the family needs help.[9] Teens who live in more affluent families and those who live with both parents have higher education aspirations and expectations, are more engaged in school, do better academically and are more likely to continue their schooling than their peers in less well-off families and those in single-parent families.[10]

Nationally, the tendency to miss school either by skipping or for other reasons increased notably by grade level. Over the past two decades, twelfth graders have reported a declining interest in school.[11]

Students are very aware of whether their teachers have high or low expectations for them and often their achievement levels are strongly linked to those expectations. The relationships between students and their teachers are critical in shaping the school climate of the school. All students, regardless of age, will do better when relationships are respectful, behavior is not disruptive and teachers are invested in the student's success.[12]

Suspensions Due to Attendance Infractions, Rhode Island, 2001-2002 School Year

	Number	Percent of All Suspensions
Cutting/Skipping Classes	6,281	14%
Cut/Skipped Detention	5,264	12%
Left School Grounds	2,610	6%
Tardy	1,362	3%
Truancy	880	2%
Total Attendance Infractions	*16,397*	*37%*

Source: Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year

◆ During the 2001-2002 school year, more than a third (37%) of the 44,127 incidents in which a Rhode Island public school student received a suspension or alternative program placement were due to attendance infractions. This is more than any other single category of infractions.

◆ U.S. Students who have considered dropping out of school have skipped class or school for the following reasons: school was boring, they did not complete an assignment or they did not feel ready to take a test.[13]

◆ In Rhode Island during the 2001-2002 school year, high school attendance rates were 86% in the core cities and 92% in the remainder of state. With 13,844 high school students in the core cities, improving the core cities' attendance rate from 86% to 92% would mean that 907 more students would be attending high school in the core cities each day of the school year.[14]

◆ Effective truancy reduction strategies include clear, consistently enforced school policies; school reorganization to support students' engagement in learning and attachment to school; effective communication between the school and the parent; family counseling programs; and collaboration between the school and community partners.[15]

Table 33

School Attendance Rates, Rhode Island, 2001-2002

SCHOOL DISTRICT	ELEMENTARY SCHOOL		MIDDLE SCHOOL		HIGH SCHOOL	
	NUMBER ENROLLED	ATTENDANCE RATE	NUMBER ENROLLED	ATTENDANCE RATE	NUMBER ENROLLED	ATTENDANCE RATE
Barrington	1,549	96%	752	96%	985	95%
Bristol-Warren	1,693	95%	944	94%	1,173	89%
Burrillville	1,175	95%	667	94%	907	95%
Central Falls	1,860	94%	930	91%	848	86%
Chariho	1,582	95%	1,105	95%	1,200	93%
Coventry	3,014	96%	921	95%	1,850	91%
Cranston	5,182	96%	2,721	94%	3,252	90%
Cumberland	2,554	96%	1,318	96%	1,501	92%
East Greenwich	1,368	97%	400	96%	672	95%
East Providence	2,919	95%	1,604	93%	2,043	87%
Exeter-W. Greenwich	1,141	96%	386	96%	625	93%
Foster	402	96%	NA	NA	NA	NA
Foster-Glocester	NA	NA	745	94%	887	93%
Glocester	802	96%	NA	NA	NA	NA
Jamestown	330	96%	258	96%	NA	NA
Johnston	1,645	95%	885	99%	851	87%
Lincoln	2,051	97%	578	95%	1,077	93%
Little Compton	216	95%	NA	NA	NA	NA
Middletown	1,187	96%	834	95%	835	92%
Narragansett	622	93%	583	95%	537	94%
New Shoreham	66	92%	34	91%	30	91%
Newport	1,446	93%	655	91%	836	87%
North Kingstown	2,109	96%	1,056	95%	1,336	93%
North Providence	1,631	95%	794	95%	1,051	93%
North Smithfield	1,052	96%	273	95%	536	94%
Pawtucket	5,419	95%	2,134	94%	2,280	89%
Portsmouth	1,128	96%	924	96%	836	95%
Providence	13,970	92%	6,285	88%	6,904	83%
Scituate	813	96%	446	96%	513	94%
Smithfield	1,217	96%	675	95%	841	93%
South Kingstown	1,925	96%	1,088	95%	1,331	93%
Tiverton	776	96%	778	94%	668	92%
Warwick	6,411	96%	2,015	94%	3,796	92%
West Warwick	1,819	95%	886	93%	1,090	91%
Westerly	1,715	96%	893	95%	1,083	94%
Woonsocket	3,354	94%	1,520	93%	1,886	86%
Core Cities	*27,868*	*93%*	*12,410*	*90%*	*13,844*	*86%*
Remainder of State	*48,275*	*96%*	*23,677*	*95%*	*30,416*	*92%*
Rhode Island	*76,143*	*95%*	*36,087*	*93%*	*44,260*	*90%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the total number of students enrolled in the school district.

References for Indicator

[1] *Trends in the Well-Being of America's Children and Youth (2001)*. Washington, DC: Office of the Assistant Secretary of Planning and Evaluation, U.S. Department of health and Human Services.

[2] *The Condition of Education* (1996). Washington, DC: National Center for Education Statistics.

[3] *A Report from the Kids Mobility Project* (March 1998). Minneapolis: The Kids Mobility Project.

[4, 13] *Student Truancy, ERIC Digest, Number 125* (1999). Eugene OR: ERIC Clearinghouse on Educational Management.

[5, 14] *The MetLife Survey of the American Teacher. Student Life: School, Home and Community* (2002). New York, NY: MetLife, Inc.

[6] *Manual to Combat Truancy: The Problem of Truancy in America's Communities* (July 1996). Washington, DC: U.S. Department of Education and U.S. Department of Justice.

[7, 8] *Truancy, Literacy and the Courts, A User's Manual for Setting Up a Truancy Intervention Program* (2001). Washington, DC: The American Bar Association.

[9] *Urban Policies and Programs to Reduce Truancy* (1997). Clearinghouse on Urban Education, ERIC DIGEST.

[10] *Educating America's Youth: What Makes a Difference* (2002). Washington, DC: Child Trends.

[11] *The Condition of Education* (2002). Washington, DC: Office of Educational Research and Improvement, U.S. Department of Education.

[12] *Learning Support Indicators: Technical Assistance Bulletin* (2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[15] Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

Suspensions

DEFINITION

Suspensions is the rate of infractions and disciplinary actions per 100 students in kindergarten through twelfth grade in Rhode Island public schools. Disciplinary actions include in-school suspensions, out-of-school suspensions, and alternative program placements. Data are for the 2001-2002 school year.

SIGNIFICANCE

Effective school discipline strategies focus on ensuring the safety of students and staff, encouraging responsible behavior, and creating an environment conducive to learning.[1] During the 2001-2002 school year, 17,836 of Rhode Island's 158,046 students were suspended for 44,127 infractions. This is a rate of 28 disciplinary actions per 100 students.[2] The most common discipline problems in schools involve non-criminal student behavior that is disruptive of the learning environment.[3] More than one third of the 44,127 infractions resulting in disciplinary action in Rhode Island were attendance infractions, including skipping class, skipping detention and tardiness.[4] Possession of drugs or weapons accounted for 729 disciplinary actions, 2% of all infractions.[5]

Schools may take any number of actions when a student is disruptive, interferes with the learning of other students, or affects the safety of others. Research shows that the best approach to school discipline is a balance between clearly communicated and consistently enforced rules and a climate of concern for students as individuals. Smaller schools – or larger schools divided into "schools within schools" – are better able to address the individual needs of students.[6] Students who dislike school, do poorly academically, and have limited career objectives are more likely to be disruptive.[7,8] Students with discipline problems have lower test scores. Students who have discipline problems are more likely to drop out of school.[9,10]

During the 2001-2002 school year, 28% of the suspensions in Rhode Island public schools involved students enrolled in special education.[11] Minority children and poor children in Rhode Island are also more likely to be suspended.[12] The Task Force on Racial Bias and School Discipline concluded in its report that there is evidence that both race and economic status are factors in school suspensions. The Task Force reported that as many as one-third of Rhode Island school districts show an over-representation of minorities in suspension data.[13]

Disciplinary Actions, Rhode Island Public Schools, 2001-2002

By Type of Infraction	Number	Percent
Attendance Offenses	9,771	22%
Cut/Skipped Detention/Tardy	6,626	15%
Insubordination/Disrespect	6,166	14%
Disorderly Conduct	6,393	14%
Other Offenses*	3,836	9%
Fighting	3,000	7%
Assault	2,138	5%
Obscene /Abusive Language	2,077	5%
Harassment	742	2%
Larceny/Theft/Vandalism/Arson	782	2%
Threat/Intimidation	941	2%
Tobacco/Alcohol Offenses	926	2%
Drug Offenses	418	1%
Weapon Possession	311	1%
Total	*44,127*	*100%*

*Examples of other offenses includes forgery, trespassing and communication/electronic devices

◆ During the 2001-2002 school year, there were 44,127 incidents in which a Rhode Island public school student received a suspension or alternative program placement. The 44,127 suspensions can be attributed to 17,836 students.

◆ In Rhode Island public schools, high school students are more likely to be suspended than elementary and middle school students. During the 2001-2002 school year, 60% of suspensions were to high school students (grades 9-12), 34% were to middle school students (grades 6-8), and 6% were to elementary students (grades K-5).

◆ Of the 44,127 suspensions to Rhode Island public school students of all grades, 58% were out-of-school suspensions, 34% were in-school suspensions and 8% were alternate program placements.

Source: Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

Table 34.

Disciplinary Actions, Rhode Island School Districts, 2001-2002

SCHOOL DISTRICT	# OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	TOTAL DISCIPLINARY ACTIONS	RATE PER 100 STUDENTS
Barrington	3,286	136	8	0	144	4
Bristol-Warren	3,810	751	1,037	0	1,788	47
Burrillville	2,749	268	808	25	1,101	40
Central Falls	3,638	990	806	3	1,799	49
Chariho	3,887	345	984	54	1,383	36
Coventry	5,785	821	828	20	1,669	29
Cranston	11,155	2,364	0	0	2,364	21
Cumberland	5,373	449	32	2	483	9
East Greenwich	2,440	93	56	1	150	6
East Providence	6,566	470	4	0	474	7
Exeter-W. Greenwich	2,152	383	17	1	401	19
Foster	402	0	0	0	0	0
Foster-Glocester	1,632	449	0	0	449	28
Glocester	802	2	2	0	4	1
Jamestown	588	0	0	0	0	0
Johnston	3,381	714	445	1	1,160	34
Lincoln	3,706	582	4	61	647	17
Little Compton	350	3	0	0	3	1
Middletown	2,856	235	1,087	0	1,322	46
Narragansett	1,742	164	174	2	340	20
New Shoreham	130	0	1	0	1	1
Newport	2,937	961	200	11	1,172	40
North Kingstown	4,501	340	116	0	456	10
North Providence	3,476	490	546	0	1,036	30
North Smithfield	1,861	295	0	0	295	16
Pawtucket	9,833	1,465	15	2	1,482	15
Portsmouth	2,888	92	30	711	833	29
Providence	27,159	5,863	2,961	5	8,829	33
Scituate	1,772	162	334	0	496	28
Smithfield	2,733	201	534	0	735	27
South Kingstown	4,344	747	81	1	829	19
Tiverton	2,222	265	988	15	1,268	57
Warwick	12,222	2,063	17	2,391	4,471	37
West Warwick	3,795	434	591	0	1,025	27
Westerly	3,691	326	1	0	327	9
Woonsocket	6,760	2,234	1,867	16	4,117	61
State-Operated / Charter	*1,422*	*629*	*338*	*106*	*1,073*	*76*
Core Cities	*54,122*	*11,947*	*6,440*	*37*	*18,424*	*34*
Remainder of State	*103,924*	*13,839*	*8,472*	*3,391*	*25,702*	*25*
Rhode Island	*158,046*	*25,786*	*14,912*	*3,428*	*44,126*	*28*

Notes to Table

Suspension rate per 100 students is based on the total disciplinary actions for the school district at all grade levels. The denominator is the total number of students enrolled in kindergarten through 12th grade in the school district.

Total disciplinary actions is the number of incidents resulting in suspension - either in-school or out-of-school, or placement of the student in an alternate program. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year. The difference between the total number of suspensions by districts and suspensions by type of infraction is "missing" or invalid cases.

Expulsion can no longer be reported as a separate category because under Rhode Island law schools cannot expel students. Therefore, expulsions are included in the out-of-school suspension category.

Suspension policies vary by district. The type of infraction resulting in disciplinary action varies according to school district policy. The type of disciplinary action used for each type of infraction also varies according to school district policy.

State operated and charter schools includes data for the Rhode Island School for the Deaf, Davies Career Technical School, and Metropolitan Career Technical Center, Area Career Technical Schools, the Paul Cuffee Charter School and the Urban Collaborative Accelerated Program.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

References for Indicator

[1,2,3] Gaustad, J. (1992). *School Discipline*. Eugene, OR: ERIC Clearinghouse on Educational Management, ERIC Digest, Number 78.

[4,5,11,12] Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

[6,7] *Order in the Classroom* (October 1998). Princeton, NJ: Educational Testing Center, Policy Information Center, Research Division.

[8] The MetLife Survey of the American Teacher: *Students' Life, School, Home and Community* (2002). New York, NY: MetLife, Inc.

[9,10] *Rhode Island Racial Bias and School Discipline Task Force Report to Commissioner Peter McWalters* (2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using fall enrollment data and the number of students who dropped out between October 2, 2000 and October 1, 2001. It is a four-year cumulative rate, and represents the probability of an individual student graduating from high school.

SIGNIFICANCE

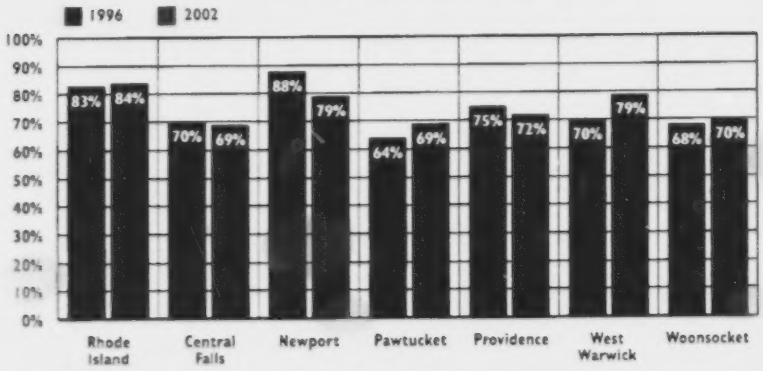
A high school diploma should represent acquisition of the basic reading, writing, and mathematics skills a person needs to function in modern society.[1] Student achievement and graduation rates can be improved when schools have high expectations for all students; have effective and up-to-date curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.[2]

Several factors contribute to a student's decision to leave school. Ongoing patterns of absenteeism, poor grades, and poor achievement on tests are linked to dropping out. Schools with high concentrations of low-achieving students and less-qualified teachers have higher dropout rates.[3] Students can benefit from access to a broad range of community supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[4]

In 2002 in Rhode Island, 87% of White students, 83% of Asian students, 76% of Black students, and 72% of Latino students graduated from high school.[5] Nationally, low-income students are three times more likely to drop out than middle-income students.[6]

Youth who drop out of school are more likely to rely on public assistance as adults.[7] In 1999, over half of the people over 25 who did not have a high school diploma or GED reported no earnings during that year.[8] In 2000, people without a high school diploma who found employment earned a median income of $10,838 compared to $18,571 for people with a high school degree or equivalent.[9] Female dropouts are much more likely to live in poverty than male dropouts of the same racial or ethnic group.[10] Young women who drop out of school are more likely to have children at younger ages and more likely to be single parents than high school graduates.[11]

High School Graduation Rate, Core Cities and Rhode Island, 1996-2002



Source: Rhode Island Department of Elementary and Secondary Education

◆ Between 1996 and 2002, the graduation rate in Rhode Island did not improve significantly. Of the six communities with the highest child poverty rates, three (Central Falls, Newport and Providence) experienced a decrease in the percentage of students graduating from high school and three (Pawtucket, West Warwick, and Woonsocket) experienced improvements.[12]

◆ National research on dropout prevention programs highlights the importance of children's early education.[13] High quality early care and education and smaller class sizes in early elementary school are shown to improve academic achievement and high school completion later in life.[14] At-risk students benefit most from ongoing support, remediation, and counseling in the early elementary school grades.[15]

The Role of the GED in Rhode Island

◆ The General Educational Development (GED) certificate offers a valuable alternative for youth and adults lacking a high school diploma. In 2001, over 655,000 Americans, including 2,369 Rhode Islanders, earned their GED credential.[16] While the GED improves access to jobs, studies show that the GED has less value than a traditional diploma as a tool for pursuing advanced education and employment opportunities.[17,18]

Table 35.

High School Graduation Rate, Rhode Island, 2002

	COMMUNITY CONTEXT						
SCHOOL DISTRICT	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	2001 GRADUATION RATE
Barrington	4%	92%	3,286	<1%	4%	86%	90%
Bristol-Warren	12%	NA	3,810	4%	4%	58%	82%
Burrillville	5%	80%	2,749	<1%	2%	58%	87%
Central Falls	37%	49%	3,638	30%	74%	35%	69%
Chariho	6%	NA	3,887	<1%	3%	57%	94%
Coventry	8%	83%	5,785	<1%	3%	53%	90%
Cranston	8%	79%	11,155	4%	16%	55%	84%
Cumberland	3%	81%	5,373	3%	6%	61%	93%
East Greenwich	5%	93%	2,440	1%	5%	91%	97%
East Providence	9%	71%	6,566	5%	18%	56%	80%
Exeter-W. Greenwich	5%	NA	2,152	1%	3%	64%	93%
Foster	6%	88%	402	0%	4%	NA	NA
Foster-Glocester	4%	NA	1,632	0%	1%	62%	89%
Glocester	8%	87%	802	0%	3%	NA	NA
Jamestown	3%	93%	588	<1%	3%	NA	NA
Johnston	9%	78%	3,381	2%	8%	71%	91%
Lincoln	6%	82%	3,706	1%	6%	71%	99%
Little Compton	1%	91%	350	0%	0%	NA	NA
Middletown	9%	91%	2,856	1%	14%	70%	90%
Narragansett	10%	91%	1,742	<1%	5%	73%	89%
New Shoreham	11%	95%	130	2%	6%	NA	NA
Newport	24%	87%	2,937	3%	38%	73%	79%
North Kingstown	11%	92%	4,501	1%	5%	77%	92%
North Providence	9%	77%	3,476	3%	14%	45%	85%
North Smithfield	2%	82%	1,861	<1%	2%	75%	94%
Pawtucket	21%	66%	9,833	12%	45%	45%	69%
Portsmouth	3%	91%	2,888	<1%	4%	79%	97%
Providence	37%	66%	27,159	23%	84%	79%	72%
Scituate	4%	87%	1,772	0%	2%	69%	91%
Smithfield	4%	85%	2,733	0%	2%	75%	92%
South Kingstown	6%	91%	4,344	1%	10%	84%	91%
Tiverton	3%	80%	2,222	0%	2%	81%	87%
Warwick	8%	85%	12,222	1%	5%	61%	93%
West Warwick	18%	76%	3,795	2%	11%	61%	79%
Westerly	11%	82%	3,691	2%	7%	57%	92%
Woonsocket	27%	64%	6,760	6%	38%	50%	70%
Core Cities	*30%*	*NA*	*54,122*	*17%*	*63%*	*64%*	*NA*
Remainder of State	*7%*	*NA*	*102,502*	*2%*	*8%*	*63%*	*NA*
Rhode Island	*15%*	*78%*	*156,624*	*7%*	*27%*	*64%*	*84%*

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1999. % of adults completing high school or higher is from Census 2000. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2001-2002 school year.

The denominator for the indicator is the number of children enrolled in 9th, 10th, 11th, and 12th grades in the fall of 2001. NA: Community has a regional high school.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References

[1] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] *Years of Promise: A Comprehensive Learning Strategy for America's Children* (1996). New York, NY: Carnegie Corporation of New York.

[3][4][5] *Understanding Dropout: Statistics, Strategies, and High-Stakes Testing* (2001). Washington, DC: National Academy Press.

[6] *Reducing the High School Dropout Rate* (July 2002). Baltimore, MD: The Annie E. Casey Foundation.

[7][8] Rhode Island Department of Elementary and Secondary Education.

[9][10] *Dropout Rates in the United States: 2000* (2001). Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

[11] Brown, B. (August 2001). *Teens, Jobs, and Welfare: Implications for Social Policy*. Washington, DC: Child Trends.

[12] Greene, J. (November 2001). *High School Graduation Rates in the United States*. New York, NY: Black Alliance for Educational Options and the Center for Civic Innovation at the Manhattan Institute.

[13] U.S. Bureau of the Census. *Income in 1999 by Educational Attainment for People 18 Years Old and Over, by Age, Sex, Race, And Hispanic Origin, March 2000*. Revised October 2002.

[14] Phillips, L. (1998). *The Girls Report: What We Know and Need to Know About Growing Up Female*. New York, NY: National Council for Research on Women.

[15] Redd, Z., et al. *Educating America's Youth: What Makes a Difference* (August 2002). Washington, DC: Child Trends.

[16] *Who Took the GED? GED 2001 Statistical Report* (2002). Washington, DC: American Council on Education, GED Testing Service.

[17] Murnane, R. and Tyler, J. "The Increasing Role of the GED in American Education" *Education Week* Vol. 19, No. 34 (May 3, 2000). Bethesda, MD: Editorial Projects in Education Inc.

Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

Improving educational and employment opportunities is especially important for urban disadvantaged and minority youth.[1] Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[2] Caring parent-child interactions, positive peer influences, and support from siblings, teachers and mentors can greatly influence a teen's choices and attitudes.[3,4] Mentoring can have a particularly beneficial impact on an adolescent's development. Mentored youth are likely to have fewer absences from schools, better attitudes towards school, less drug and alcohol use, and improved relationships with their parents.[5,6] Employment programs also show potential for exposing youths to supportive relationships and for reducing criminal behavior.[7]

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood.[8] These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[9,10] They are also at an especially high risk for teen parenting, crime and negative behaviors.[11] In addition, they are more likely to need public assistance.[12,13]

An increasing number of new jobs are available only to those with higher skill levels. By 2008, nearly one in four jobs will require at least a bachelor's degree, and 70% of the fastest-growing jobs will require at least some postsecondary education.[14,15]

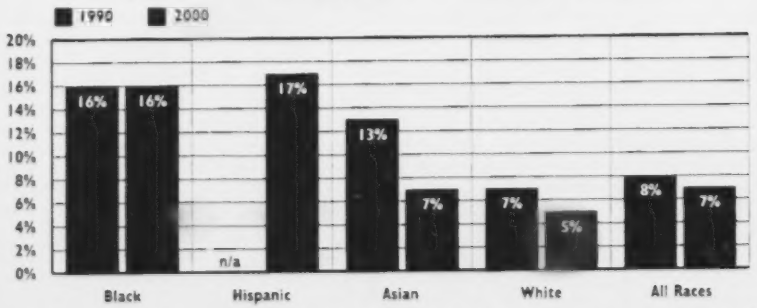
Teens Not In School and Not Working

	1990	2000
RI	10%	7%
US	10%	9%
State Rank		*12th*

1st is best; 50th is worst

Source: *Children at Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Teens Not in School and Not Working, Ages 16 to 19, by Race and Ethnicity, Rhode Island, 1990 and 2000



Note: Comparable data on Hispanics was not collected in the 1990 Census. For both 1990 and 2000 data, Hispanics may be of any race.

Source: U.S. Bureau of the Census, 1990 Census of the Population and Census 2000.

◆ In 2000, 7% of Rhode Island teens ages 16 to 19 were neither enrolled in school nor working. This was 4,477 youth ages 16 to 19. In 2000, 17% of Hispanic youth, 16% of Black youth, and 7% of Asian youth were not in school and not employed as compared to 5% of White youth.[16]

◆ Over the past decade, the percentage of Asian youth who were not in school and not employed decreased by almost half, dropping from 13% to 7%. The percentage remained stable or decreased slightly among other racial and ethnic groups for whom data are available.[17]

◆ The communities with the highest rates of teens not in school and not working in 2000 were Central Falls (16.5%), Cranston (15.0%), Pawtucket (13.4%), Warren (13.0%) and Woonsocket (11.7%).[18]

Table 36. **Teens Not in School and Not Working, Ages 16-19, Rhode Island, 2000**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	816	7	11	18	2.2%
Bristol	1,701	0	23	23	1.4%
Burrillville	980	3	14	17	1.7%
Central Falls	1,082	66	112	178	16.5%
Charlestown	320	0	0	0	0.0%
Coventry	1,632	9	50	59	3.6%
Cranston	4,233	304	329	633	15.0%
Cumberland	1,449	67	28	95	6.6%
East Greenwich	636	0	0	0	0.0%
East Providence	2,068	75	55	130	6.3%
Exeter	251	5	0	5	2.0%
Foster	232	0	0	0	0.0%
Glocester	551	5	10	15	2.7%
Hopkinton	402	4	16	20	5.0%
Jamestown	267	0	5	5	1.9%
Johnston	1,080	33	17	50	4.6%
Lincoln	974	0	26	26	2.7%
Little Compton	175	0	16	16	9.1%
Middletown	713	37	18	55	7.7%
Narragansett	739	9	12	21	2.8%
New Shoreham	26	0	0	0	0.0%
Newport	1,740	31	100	131	7.5%
North Kingstown	1,159	13	0	13	1.1%
North Providence	1,262	22	38	60	4.8%
North Smithfield	494	0	0	0	0.0%
Pawtucket	3,684	203	292	495	13.4%
Portsmouth	736	0	12	12	1.6%
Providence	15,673	420	1,138	1,558	9.9%
Richmond	326	16	0	16	4.9%
Scituate	604	44	17	61	10.1%
Smithfield	1,904	11	11	22	1.2%
South Kingstown	3,532	8	11	19	0.5%
Tiverton	769	23	22	45	5.9%
Warren	507	33	33	66	13.0%
Warwick	3,843	60	130	190	4.9%
West Greenwich	300	0	0	0	0.0%
West Warwick	1,341	47	73	120	8.9%
Westerly	1,029	24	23	47	4.6%
Woonsocket	2,179	75	181	256	11.7%
Core Cities	*25,699*	*842*	*1,896*	*2,738*	*10.7%*
Remainder of State	*35,710*	*812*	*927*	*1,739*	*4.9%*
Rhode Island	*61,409*	*1,654*	*2,823*	*4,477*	*7.3%*

Sources of Data for Table/Methodology

U.S. Bureau of the Census, Census 2000.

Core cities are Central Falls, Pawtucket, Providence, Newport, West Warwick and Woonsocket.

The denominator is the number of teens ages 16 to 19 according to Census 2000.

References for Indicator

[A2] *Reducing the Number of Disconnected Youth* (July 2002). Baltimore, MD: The Annie E. Casey Foundation.

[2] Hughes, K. L., Bailey, et al (2001). *School-to-Work: Making a Difference in Education*. New York, NY: Institute on Education and the Economy, Teachers College, Columbia University.

[3] Moore, K.A. et al (November 2002). *Building a Better Teenager: A Summary of What Works in Adolescent Development*. Washington, DC: Child Trends.

[4] Jekielek, M.A. et al (February 2002). *Mentoring: A Promising Strategy for Youth Development*. Washington, DC: Child Trends.

[5] Jekielek, S. et al (May 2002). *Employment Programs and Youth Development: A Synthesis*. Washington, DC: Child Trends.

[6] [7] *America's Children: Key National Indicators of Well-Being 2002* (2002). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

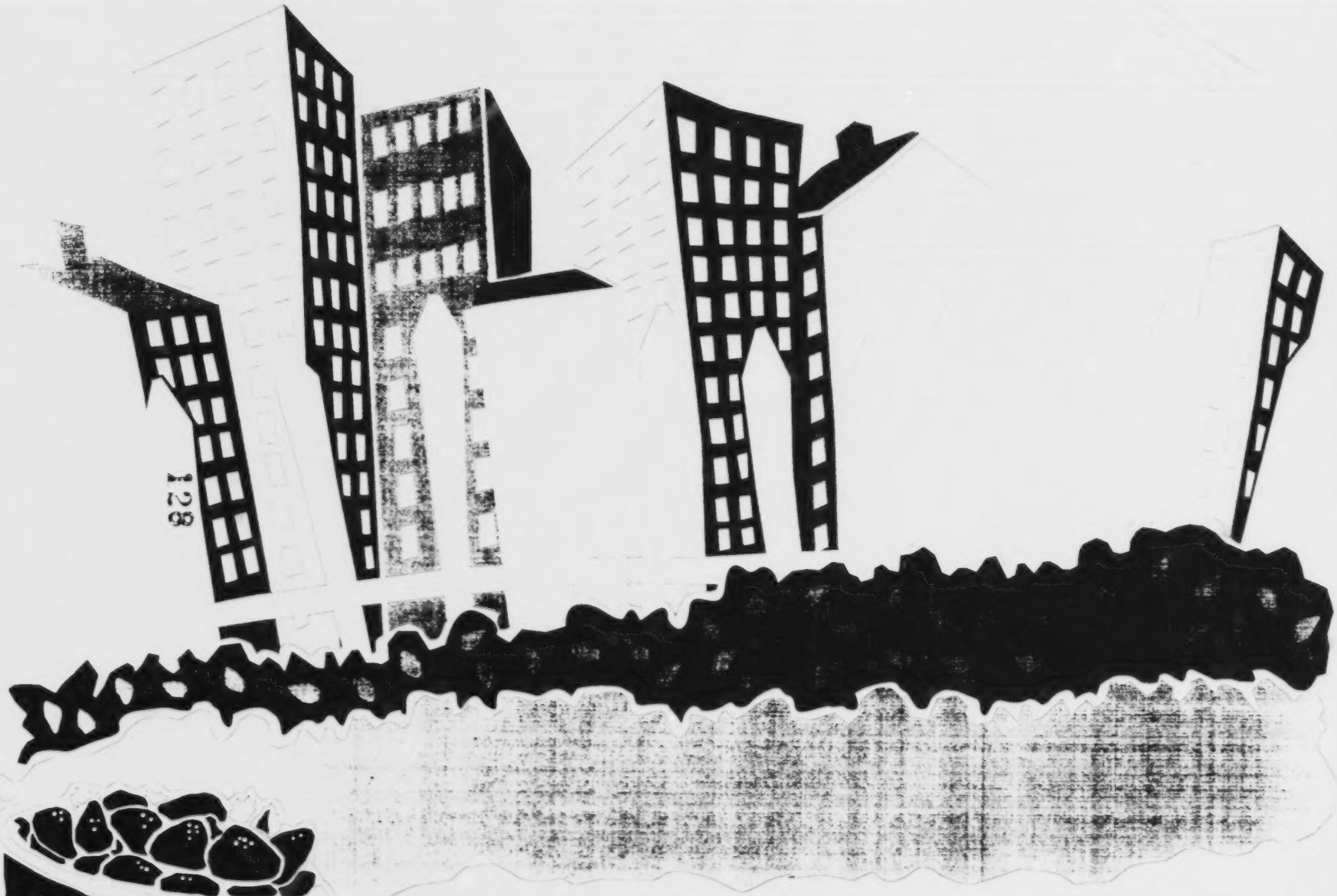
[8] Brown, B. (August 2001). *Teens, Jobs, and Welfare: Implications for Social Policy*. Washington, DC: Child Trends.

[9] Mroz, Thomas A. et al (October 2001). *The Long-Term Effects of Youth Unemployment*. Washington, DC: Employment Policies Institute.

[A] Fleerwood, C. et al (Fall 2000). "The Outlook for College Graduates, 1998-2008: A Balancing Act". *Occupational Outlook Quarterly*.

[B] Haycock, K. and S. Huang (Winter 2001). "Are Today's High School Graduates Ready?" in *Thinking K-16*, Vol. 5, No. 1. Washington, DC: The Education Trust.

[C] [D] *U.S. Bureau of the Census, 1990 Census of the Population and Census 2000.*



Methodology and Acknowledgements

Methodology

The *2003 Rhode Island KIDS COUNT Factbook* examines 52 indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

- ***Definition:*** A description of the indicator and what it measures.
- ***Significance:*** The relationship of the indicator to child and family well-being.
- ***Sidebars:*** Current state and national data and information related to the indicator.
- ***State Rank:*** For those indicators that are included in the Annie E. Casey Foundation's KIDS COUNT publications, the Factbook highlights Rhode Island's rank among the 50 states and trends since 1990. These data are from either the *2002 KIDS COUNT Data Book, Children At Risk: State Trends 1990 to 2000* or *The Right Start for America's Newborns: A Decade of City and State Trends (1990 - 2000)*. Data from the three publications come from different data sources depending on the indicator.
- ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.
- ***Core Cities Data:*** Six core cities are identified based on high child poverty rates: Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 2000 Census.
- ***Most Recent Available Data:*** The 2003 Factbook uses the most current, reliable data available for each indicator.
- ***New Indicators:*** Three new indicators have been added to the 52 indicators included in the *2003 Rhode Island KIDS COUNT Factbook*: "Mother's Education Level", "Childhood Immunizations" and "Adoption and Permanency". *The 2003 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

The *2003 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period - e.g., the number of child deaths between 1997 and 2001. Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event - e.g., out of every 1,000 live births, how many infants will die before their first birthday. A percentage is another measure of the probability of an event - e.g., out of every 100 births, how many will be born low birthweight. Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percent, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e., the "denominator") is also noted within the Source of Data/Methodology section. Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Use of Census 2000 Data

Wherever possible data from Census 2000 was included in the 2003 Factbook. When Census 2000 data have been substituted in denominators, this

was noted in the note to the table. Caution should be taken when comparing new rates with past years as the population numbers used in the denominator have changed for all cities and towns. Otherwise, when Census 2000 data were not yet available, three-year averages were used from the Current Population Survey.

Methodology for Children Receiving Child Support Indicator

Estimated Number of Children in the Child Support Enforcement System: Beginning in the *2002 Factbook*, this number is higher than in previous years because it includes Rhode Island children for whom the Child Support Enforcement Office collects and disburses child support payments, regardless of whether or not the Child Support Enforcement Office is providing the family with services related to paternity establishment or child support enforcement.

Methodology for Infant and Pre-school Child Care Indicator

Estimated Number of Children in Need of Regulated Care is computed by: multiplying the Census 2000 number of children under age 6 with both or only parent in the workforce by 58.4% (the percent of U.S. women with children under age 6 who used center based care or other non-relative care as their child care arrangement as reported by the U.S. Census Bureau Survey of Income and Program Participation data from Spring 1997). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 2002.

Methodology for Children Receiving Child Care Subsidies

The Number of Children Receiving Child Care Subsidies in a licensed child care center or a certified family child care home is the total number of children for whom the Rhode Island Department of Human Services paid a full or part-time subsidy as of December 2002. All data are based on the location of the child care program where the child receives services, not the residence of the child.

Estimated Number of Children Under age 16 Eligible for Child Care Subsidies: The number of children under age 16 in working families under 185% of the Federal Poverty Level (FPL) is computed by: multiplying the number of children under age 16 living in households with income below 185% of the federal poverty threshold as reported in Census 2000 by the percent of children under age 18 living in families with only or both parents in the workforce as reported in Census 2000.

Methodology for Fourth Grade Reading Scores

As of 2000, the manner in which reading scores are calculated changed. In the past, a student was counted as a test taker only if they actually took the test and completed enough of it for a score to be calculated. As of 1999-2000, however, all students eligible to take the test are counted, whether or not they take the test or score. All students are eligible unless their IEP specifically exempts them or unless they are Beginning English Language Learners. As a result, overall proficiency rates, as reported here, are lower than they were under the previous system of scoring. For instance, in 1999, under the previous system of scoring, 84% of fourth graders were proficient in basic understanding and 69% in interpretation and analysis.

Methodology for High Performing Schools

A school is "improving" if between 1998-2000 and 2001-2002 there was at least a 3% increase in the percentage of students who demonstrate proficiency (in math and/or English language arts) and at least a 3% decrease in the percentage of students in the two lowest achievement levels plus "no score" category. These improvements must occur on 2 out of 3 math subtests and/or in 3 out of 4 English language arts subtests.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 51 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems. In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 2001 using the Current Population Survey, 2000 - 2002 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 2000 Census when available.

continued, next page

Methodology

Family Income Levels Based on the Federal Poverty Measures

The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes — for instance, estimating the number of children in Rhode Island living in poor families. The poverty threshold is adjusted upward based on family size and whether or not household members are children, adults or 65 years and over. The 2002 federal poverty threshold for a family of three with two children is $14,494 and $18,244 for a family of four with two children.

The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs. Often, government assistance programs, including many of those administered by the state of Rhode Island use the federal poverty guidelines to determine income eligibility. The figures are adjusted upward for larger family sizes.

Family Income Levels Based on the Federal Poverty Guidelines

2003 Federal Poverty Guidelines	Annual Income Family of Three	Annual Income Family of Four
50%	$7,630	$ 9,200
100%	$15,260	$18,400
130%	$19,838	$23,920
185%	$28,231	$34,040
200%	$30,520	$36,800
225%	$34,335	$41,400
250%	$38,150	$46,000

Source: 2002 Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services.

(continued from page 31)

References for Children in Poverty

[1] "Child Poverty Tops 50 Percent in 14 U.S. Counties: CDF Ranks Worst Areas for Child Poverty Nationwide" (June 2002). Washington DC: Children's Defense Fund.

[2] *Early Childhood Poverty: A Statistical Profile* (March 2002). New York, NY: National Center for Children in Poverty.

[3] Rhode Island Department of Human Services, INRHODES Database, December 2002.

[4,5] *The 2001 Rhode Island Standard of Need* (2002). Providence, RI: The Poverty Institute at Rhode Island College.

[6] Smith, K. (October 2000). *Who's Minding the Kids?* Washington, DC: U.S. Census Bureau.

[7] *The Value of Housing Subsidies to Welfare Reform Efforts* (February 2000). Washington, DC: Center on Budget and Policy Priorities.

[8] Rhode Island KIDS COUNT Calc.. ations using data from Rhode Island Housing and Mortgage Finance Corporation.

(continued from page 95)

References for Infant and Pre-School Child Care

[1] Schumacher, R. et al. (October 1999). *Child Care after Leaving Welfare: Early Evidence from State Studies*. Washington, DC: Center for Law and Social Policy.

[2] *Care Around the Clock: Developing Child Care Resources Before Nine and After Five, Executive Summary* (1995). Washington, DC: Women's Bureau, U.S. Department of Labor.

[3] Park-Jadotte, J. et. al. (2002). *Building a Stronger Child Care Workforce: A Review of Studies of the Effectiveness of Public Compensation Initiatives*. Washington, DC: Institute for Women's Policy Research.

[4] Options for Working Parents, Providence, RI (December, 2002)

[5] *The National Economic Impacts of the Child Care Sector* (Fall 2002). Prepared by M Cubed and Sponsored by The National Child Care Association.

[6] Masse, L. et al. (2002). *A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention*. New Brunswick, New Jersey: National Institute for Early Education Research.

[7,8] Phillips, D. et. al. (2001). "*Child Care and Our Youngest Children*" *in The Future of Children: Caring for Infants and Toddlers: Spring/Summer 2001*, Vol.11, No. 1. Los Altos, CA: The David and Lucile Packard Foundation.

[9] Larner, M. et. al. (2001). "*Caring for Infants and Toddlers: Analysis and Recommendations*" *in The Future of Children: Caring for Infants and Toddlers: Spring/Summer 2001*, Vol.11, No. 1. Los Altos, CA: The David and Lucile Packard Foundation.

(continued from page 101)

References for Children Receiving Child Care Subsidies

[1] Oliver, H. et. al. (June 2002). *Eligibility for CCDF-Funded Child Care Subsidies Under the October 1999 Program Rules*. Washington, DC: U.S. Department of Health and Human Services.

[2,3,4] Rhode Island Department of Human Services, INRHODES Database, December 2002.

[5] Giannarelli, L. et. al. (February 2003). *Getting Help with Child Care Expenses*. Washington, DC: The Urban Institute.

[6] *Stepping Up! Out-of-School Time and Youth Development in Providence: A School-Community Analysis* (January 2003). Prepared for the Providence School Department and United Way of Rhode Island, by Community Matters.

Rhode Island KIDS COUNT Committees

Rhode Island State Agency Directors and Data Liaisons to KIDS COUNT

Robert Higgins
Alvin Johnson
Department of Administration

Patricia Nolan, MD
William Hollinshead, MD
Samara Viner-Brown
Department of Health

Jane Hayward
Sherry Campanelli
Randy Rosati
Department of Human Services

Peter McWalters
Virginia da Mota
Kenneth Gu
Department of Elementary and Secondary Education

Marvin Perry
Linda Soderberg
Department of Labor and Training

Jay Lindgren
Leon Saunders
David Allenson
Department of Children, Youth and Families

Joseph E. Smith
Elizabeth Gilheeney
Governor's Justice Commission

Jeremiah S. Jeremiah, Jr.
David Heden
Family Court

A. Kathryn Power
Kathleen Spangler
Department of Mental Health, Retardation and Hospitals

Rhode Island KIDS COUNT Factbook Advisory Committee

Darlene Allen
Executive Director
Adoption Rhode Island

David Allenson
Senior Programmer Analyst
RI Department of Children, Youth and Families

Janet Anderson
Assistant Director
Children's Behavioral Health
RI Department of Children, Youth and Families

Thomas Anton, Ph.D.
Professor
A. Alfred Taubman Center for Public Policy
Brown University

Lenette Azzi-Lessing
Executive Director
Children's Friend & Service

C. Lee Baker
Family Preservation Coordinator
RI Department of Children, Youth and Families

Barbara Burgess
Early Childhood Coordinator
RI Department of Elementary & Secondary Specialist

Mike Burk
Policy and Legislative Assistant
RI Department of Children, Youth and Families

Jean Burritt Robertson
Research Director
Rhode Island Economic Development Corporation

Kai Cameron
Youth Opportunities Officer
Providence School Department

Sherry Campanelli
Associate Director
RI Department of Human Services

Beth Ashman Collins
Research Analyst
RI Economic Policy Council

Jack Combs
Research Administrator
A. Alfred Taubman Center for Public Policy, Brown University

Terese Curtin
Executive Director
Connecting for Children & Families

Laureen D'Ambra
State Child Advocate
Office of the Child Advocate

Virginia da Mota
Director, Office of Integrated Social Services
RI Department of Elementary & Secondary Education

Brenda Dann-Messier
Director
Dorcas Place Parent Literacy Center

Deborah DeBare
Executive Director
RI Coalition Against Domestic Violence

Elizabeth Earls
President
RI Council of Community Mental Health Organizations

Myra J. Edens, RN
Director, Pediatric Patient Services
Rhode Island Hospital

William Flynn
Coordinator, Campaign to Eliminate Childhood Poverty
George Wiley Center

Ken Fish
Director, Office of Information Services and Research
RI Department of Elementary & Secondary Education

Alexandra Freed-Santos
Executive Director
Office of Child Care
Diocese of Providence

Joseph Garlick
Executive Director
Woonsocket Neighborhood Development Corporation

Nancy Gewirtz, Ph.D.
Director, Poverty Institute
School of Social Work
Rhode Island College

Elizabeth Gilheeney
Juvenile Justice Specialist
Rhode Island Justice Commission

Mary Sylvia Harrison
President & CEO
RI Children's Crusade for Higher Education

David Heden
Chief Intake Supervisor
RI Family Court

Margaret Holland McDuff
CEO
Family Service, Inc.

William Hollinshead, MD
Medical Director
RI Department of Health
Division of Family Health

Patricia Jaehnig
Assistant Coordinator,
Office of Community Service
Justice and Peace Education
Diocese of Providence

Linda Katz
Policy Director
The Poverty Institute
RI College School of Social Work

Dennis B. Langley
Executive Director
Urban League of Rhode Island

continued, next page

Rhode Island KIDS COUNT Committees

Tricia Leddy
Director, Center for Child and Family Health
RI Department of Human Services

Cathy Lewis
Team Leader
Casey Family Services

Peter Marino
Director of Policy
Rhode Island Public Expenditure Council

Patricia Martinez
Director of Community Relations
Office of the Governor

Michael Msall, MD
Child Development Center
Hasbro Children's Hospital

Reeva Sullivan Murphy
Child Care Administrator
RI Department of Human Services

Ana Novais
Minority Health Coordinator
RI Department of Health

Maura O'Brien
Research Coordinator
Rhode Island Housing
and Mortgage Finance Corporation

Candace Powell
Director, Maternal and Child Health
Visiting Nurse Services of Newport
and Bristol County

Larry Pucciarelli
Head Start Collaboration Project Director
RI Department of Human Services

Randy Rosati
Chief Human Services Policy
& Systems Specialist
RI Department of Human Services

Hillary Salmons
Vice President for Program Development
Health and Education Leadership for
Providence

Richard Scarpellino
Principal Deputy Clerk
Juvenile Intake Services
RI Family Court

Rick Schwartz
Vice President of Communications
The Rhode Island Foundation

Kathleen M. Spangler
Executive Director
RI Department of Mental Health,
Retardation & Hospitals

Julia Valladeres
Executive Director
Options for Working Parents

Rosalind Vaz, MD
Associate Physician
Division of Adolescent Medicine
RI Hospital/Hasbro Children's Hospital

Samara Viner-Brown
Chief, Office of Data and Evaluation
Division of Family Health
RI Department of Health

Vivian Weisman
Executive Director
RI Parent Information Network

Sheila Whalen
Chief of Prevention
Behavorial Health Care Services,
MHRH

Rhode Island KIDS COUNT Community Leadership Council

Betsy Akin
March of Dimes

Darlene Allen
Adoption Rhode Island

Raymond Arsenault
Spurwink School

Robert Barge
Rhode Island Legal Services

Bernard Beaudreau
RI Community Food Bank

Adeline Becker
Education Alliance at Brown University

Kate Begin
Prevent Child Abuse RI

Stanley Block, MD
Providence Community Health Centers, Inc.

Joyce Butler
Ready to Learn Providence

Edwin Cancel
Progreso Latino

Sharon K. Carter
Newport Partnership for Families

Barbara Cavallaro
The Pawtucket Early Learning Center

Michael Cerullo

Cathy Ciano
Parent Support Network

Kerrie Jones Clark
Rhode Island Health Center Association

Brenda Clement
The Housing Network

Cynthia Garcia Coll
Brown University

Reverend E. Naomi Craig

Terese Curtin
Connecting for Children & Families

Brenda Dann-Messier
Dorcas Place Parent Literacy Center

Deborah DeBare
RI Coalition Against Domestic Violence

Robert DeBlois
Urban Collaborative Accelerated Program

Lynda Dickinson
CHILD, Inc.

Elizabeth V. Earls
RI Council of Community Mental Health Organizations

John E. Farley, Jr., MD

Louis Fazzano
Health and Education Leadership for Providence

Karen Feldman
Youth in Action

Dr. Robert Felner
National Center for Public Education and Social Policy
University of Rhode Island

Maryann Finamore-Allmark
West Bay Child Care

Patricia Flanagan, MD
Hasbro Children's Hospital

William Flynn
George Wiley Center

David Gagnon
National Perinatal Information Center

James Gannaway
Casey Family Services

Rhode Island KIDS COUNT Committees

Joseph Garlick
Woonsocket Neighborhood Development Corporation

Sarah Gleason
Reach Out and Read RI

Kathleen Gorman
University of Rhode Island
Feinstein Center for a Hunger-Free America

Teny Gross
Institute for the Study and Practice of Non-Violence

Rabbi Leslie Y. Gutterman
Temple Beth El

Roberta Hazen Aaronson
Childhood Lead Action Project

Joanne Hoffman
Moses Brown School

Reverend John Holt
RI State Council of Churches

Nondas Hurst Voll
Fund for Community Progress

Miriam Inocencio-Ricardo
Planned Parenthood of Rhode Island

Carole Jenny, MD
Hasbro Children's Hospital

Judy Jones
Rhode Island Housing and Mortgage Corporation

Susan Adler Kaplan
Educational Consultant

Barbara Fields Karlin
LISC-Rhode Island

Sister Ann Keefe
St. Michael's Rectory

Heidi Keezer
Rhode Island Parents for Progress

Louise Kiessling, MD
Memorial Hospital

Christopher Koller
Neighborhood Health Plan of Rhode Island

Shannah Kurland
Making Connections, Providence

Peg Langhammer
Sexual Assault and Trauma Resource Center of RI

Dennis Langley
Urban League of Rhode Island

Cindy Larson
RI Child Care Facilities Fund

Joseph Le
Socioeconomic Development Center for Southeast Asians

Kristin Lehoullier
City Year Rhode Island

Amanda Frye Leinhos
Dr. Martin Luther King Community Center

Victor Lerish, MD
Barrington Pediatric Associates

Benedict Lessing
Family Resources Community Action

Maureen Macera, Ph.D.
Woonsocket Education Department

Patrick McGuigan
The Providence Plan

Martha McVicker, Esq.

Fayneese Miller, Ph.D.
Brown University

Reverend James Miller
First Baptist Church in America

Clifford Montiero
NAACP, Providence Chapter

Luisa Murillo
Center for Hispanic Policy and Advocacy

Joseph Newsome
South Providence Development Corporation

Linda H. Newton
Blue Cross & Blue Shield of RI

Olga Noguera
RI Department of Human Services

Anne Nolan
Traveler's Aid Society of Rhode Island

Roger Nolan
Aquidneck Management Associates, Ltd.

Patricia Nolin
Rhode Island College

Jane Nugent
United Way of Rhode Island

William Oh, MD
Rhode Island Hospital

Keith Oliveira
RI Urban Project

Steven Ostiguy
Church Community Housing Corp.

Vidal Perez
Education Alliance at Brown University

Pauline Perkins-Moye
Newport Housing Authority

Howard Phengxophone
Southeast Asian Youth and Family Development Project

Brother Michael Reis
Tides Family Services

Marti Rosenberg
Ocean State Action Fund

Monica Schaberg, MD

Noreen Shawcross
RI Coalition for the Homeless

Henry Shelton
George Wiley Center

Peter Simon, MD, MPH
RI Department of Health

Betsy Smith
Junior League of Rhode Island

Richard Smith, MD
Landmark Junior Health Center

Allan Stein
United Way of Rhode Island

Julia Steiny
Ed Watch
The Providence Journal

John Symynkywicz
DAWN for Children

O. Rogeree Thompson
Rhode Island Superior Court

Judy Victor
Day Care Justice Co-op

Dawn Wardyga
Family Voices of Rhode Island

Vivian Weisman
Rhode Island Parent Information Network

Elizabeth Wheeler, MD
Bradley Hospital

Thomas Whitten
John Hope Settlement House

Pheamo Witcher
The Genesis Center

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Juveniles Referred to Family Court: David Heden, Marguerite DiPalma, Richard Scarpellino, Ron Pirolli, Joseph Baxter, RI Family Court; David Allenson, Mike Burk, RI Department of Children, Youth and Families; Elizabeth Gilheeney, Governor's Justice Commission; Laureen D'Ambra, Jan Dion Fontes, Office of the Child Advocate; Warren Hurlbut, Arlene J. Chorney, Roosevelt Benton, RI Training School; Cindy Soccio, Susan Brazil, Attorney General's Office; Brother Michael Reis, Tides Family Services; Robert Felner, National Center for Public Education and Social Policy, Patricia Flannagan, Hasbro Children's Hospital; Alyssa Benedict, CORE Associates.

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Full Day Kindergarten: Virginia da Mota, Barbara Burgess, Kenneth Gu, RI Department of Elementary and Secondary Education.

English Language Learners: Kenneth Gu, Susan Rorblat-Walker, RI Department of Elementary and Secondary Education.

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Student Mobility: Katie Murray, Jim Vandermillen, The Providence Plan; Julia Steiny; Robert Oberg, The Children's Crusade; Nicole Hebert, Children's Friend and Service; Terese Curtin, Connecting for Children and Families, Inc.; Christine Arouth, Newport School Department; Samara Viner-Brown, RI Department of Health; Susanna Greschner, RI Public Expenditure Council; Kenneth Gu, RI Department of Elementary and Secondary Education.

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Poetry Credits

"She Will Gather Roses" by William Butler Yeats, reprinted from *The Oxford Illustrated Book of American Children's Poems* (1999). Edited by Donald Hall. New York, NY: Oxford University Press.

"Mother to Son" by Langston Hughes, reprinted from *Classic Poetry, An Illustrated Collection* (1998). Cambridge, MA: Candlewick Press.

"And My Heart Soars" by Chief Dan George, reprinted from *My Heart Soars* (1974). Saanichton, BC: Hancock House.

"To a Child Dancing in the Wind" by William Butler Yeats, reprinted from *Favorite Poems Old and New* (1957). Garden City, NJ: Doubleday and Company, Inc.

"Still Night Thoughts" by Li Po, reprinted from *Talking to the Sun, An Illustrated Anthology of Poems for Young People* (1985). New York, NY: Holt, Rinehart and Winston.

"Pirate Story" by Robert Louis Stevenson, reprinted from *A Child's Treasury of Poems* (1986). Edited by Mark Daniel. New York, NY: Dial Books for Young Readers.

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Rhode Island KIDS COUNT
One Union Station
Providence, RI 02903

Phone: 401-351-9400
Fax: 401-351-1758
E-Mail: rikids@rikidscount.org
Web Site: www.rikidscount.org

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